PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality Improvement
DATE: Jan. 10, 2025
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

The California Public Health Emergency has ended and Q/UAC has now returned to in-person meetings per Brown Act guidelines.
Meeting locations (and call-in information for Partnership staff only) are below and also listed on the agenda.
Please use your personal electronic device for reviewing the packet during the meeting. Hard copies will not be provided.

Meeting Time/Date: 7:30 – 8:55 a.m., Wednesday, Jan. 15, 2025
Meeting Locations:

Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle
2760 Esplanade Ave., Ste 130, Chico 95973 | Temp Conf Room

Other Locations:
Open Door Community Health Center, 3770 Janes Road, Arcata
Chapa-de Indian Health: 11670 Atwood Road, Auburn 95603
Kaiser Permanente, 5810 Owens Drive, Pleasanton, CA 94588
HHS, 5730 Packard Ave., Suite 100, Marysville, CA 95901

Staff and members only may join by Telephone: 1-844-621-3956 Access Code 809 114 256
Partnership Offices: Please use the QUAC Partnership HealthPlan's Personal Room in WebEx
https://partnershiphp.webex.com/meet/quac | 809114256 (Need assistance? Contact IT at least one (1) day prior to the meeting.)

Voting Members:
Choudhry, Sara, MD
Gwiazdowski, Steven, MD, FAAP
Hackett, Emma, MD, FACOG
Lane, Brandy, PHC Consumer Member
Luu, Phuong, MD
Montenegro, Brian, MD
Mulligan, Meagan, FNP-BC
Murphy, John, MD
Quon, Robert, MD, FACP
Strain, Michael, PHC Consumer Member
Swales, Chris, MD
Thomas, Randolph, MD
Wilson, Jennifer, MD, MPH

PHC Staff (Ex-Officio) Members:
Barresi, Katherine, RN, BSN, PHN, NE-BC, Chief Health Equity Officer
Bides, Robert, RN, BSN, Mgr, Member Safety-Quality Investigations, QI
Bontrager, Mark, Sr. Director of Behavioral Health, Health Services
Cotter, James, MD, Associate Medical Director
Cox, Bradley, DO, Regional Medical Director, Northeast
Devido, Jeffrey, MD, Behavioral Health Clinical Director
Esget, Heather, BSN, ACM-RN, Director of Utilization Management
Frankovich, Terry, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director of Care Management
Glickstein, Mark, MD, Associate Medical Director
Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Kubota, Marshall, MD, Regional Medical Director, Southwest
Leung, Stan, PharmD., Director of Pharmacy Services
Matthews, R. Douglas, MD, Regional Medical Director, Chico
Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Newman, Rachel, RN, BSN, Manager, Clinical Compliance - Inspections
O'Connell, Lisa, MHA, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, MPH, FAAP, Regional Medical Director, Northwest
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Steffen, Nancy, Senior Dir. of Quality and Performance Improvement
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director, Southeast
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

cc:
Andrews, Leigha, Regional Director, Southwest
Bjork, Sonja, JD, Chief Executive Officer
Blake, Jill, Regional Director, Auburn
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MHA/MBA, Director of Quality Management, QI
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Davis, Wendi, Chief Operations Officer
Devan, James, Manager of Performance Improvement, QI (NR)
Foster, Troy, Program Manager II, QI (HQIP)
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gual, Kristine, Director of Quality Measurement, QI
Harrell, Bria, Project Manager I, Configuration
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jarrett-Lee, Kevin, RN, Associate Director, UM
Kerlin, Mary, Senior Director of Provider Relations
Klakken, Vicki, Regional Director, Northwest
McCune, Amy, MPH, MS, Manager of Quality Incentive Programs, QI
Nakatani, Stephanie, Manager of Provider Relations Representatives
O'Leary, Hannah, MPH, Manager of Population Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Robinson, Gary, Program Manager II, Regulatory Affairs & Compliance
Sackett, Anthony, Program Manager II, QI (MEGA)
Sharp, Tim, Regional Director, Northeast
Stark, Rebecca, Regional Director, Chico

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)
MEETING AGENDA

Date: Jan. 15, 2025 **Time: 7:30 – 8:55 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
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Health & Human Services Dept., 5730 Packard Ave., Suite 100, Marysville, CA 95901

Partnership Staff only may join by Web-ex:
https://partnershiphp.webex.com/meet/quac Meeting # 809 114 256

Partnership Staff only may join by Telephone:
1-844-621-3956 Access Code: 809 114 256

This Brown Act meeting may be recorded. Any audio or video tape recording of this meeting, made by or at the direction of Partnership, is subject to inspection under the Public Records Act and will be provided without charge, if requested.

Welcome / Introductions / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of* • Nov. 20 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD	7: 30	5 - 17
2	*Acknowledgment and acceptance of draft* • Nov. 12 Internal Quality Improvement (IQI) Committee Meeting Minutes • Oct. 30, 2024 Over/Under Utilization Workgroup • Nov. 7, 2024 Substance Use Internal Quality Improvement (SUIQI) Committee • Nov. 21, 2024 Member Grievance Review Committee (MGRC) • Dec. 4, 2024 Population Needs Assessment (PNA) Committee *Community Health Assessment and Improvement Planning (CHA/CHIP) Update begins on p. 49*			19 - 64
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:33	65 - 78
2	HealthPlan Update	Robert Moore, MD	7:38	--
III.	**Old Business**			
	None			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:43	79
	2024 Oversight Audits: CY2023 Carelon – *direct questions to Gary Robinson*			81 - 82
	2024 Referral Follow-up – *direct questions to Robert Moore, MD, or Tony Hightower, CPhT*			83 - 95
	Quality Improvement Policies			
	MPQP1018 – Preventive Health Guidelines			97 - 99
	MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)			100 - 104
	Care Coordination Policies			

	Item	Lead	Time	Page #
	MCCP2018 – Advice Nurse Program			105 - 107
	MCCP2031 – Private Duty Nursing under EPSDT			108 - 113
	MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines			115 - 120
	MPCP2002 – California Children's Services – ***ARCHIVE*** *effective 01/01/2025* *Because all 24 Partnership counties are under the Whole Child Model, eff. 01/01/2025, the following policies are submitted for language changes. (There are no changes to any policy attachments.)* ***These policies will be brought back as need be on their annual review cycles:***			121 - 124
	• MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services			125 - 130
	• MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services			131 - 137
	• MCCP2023 – New Member Needs Assessment			138 - 141
	• MCCP2025 – Pediatric Quality Committee Policy			142 - 144
	• MCCP2035 – Local Health Department (LHD) Coordination			145 - 150
	• MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCN) and Persons with Developmental Disabilities			151 - 157
	Enhanced Health Services Policies			
	MCHP3142 – CalAIM Community Supports (CS)			159 - 183
	MCHP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)			184 - 188
	Utilization Management Policies			
	MCUP3034 – PCP-to-PCP Transfers & Assignments of New Members to PCP			189 - 191
	MPUP3129 – Podiatry Services			192 - 194
	Grievance & Appeals Policy			
	CGA024 – Medi-Cal Member Grievance System			195 - 217
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	219 - 221
	Quality Improvement			
	MPQP1053 – Peer Review Committee	Mark Netherda, MD	7:50	223 - 227
	Utilization Management			
	MCUG3022 – Incontinence Guidelines	Tony Hightower, CPhT	7:55	229 - 238
	MCUP3104 – Transplant Authorization Process		8:00	239 - 244
	MCUP3113 – Telehealth Services – *CLEAN copy begins on p. 261*		8:05	245 - 272
VI.	**Presentations**			
1	2024 CG-CAHPS Analysis	Amber Newell, CPhT	8:10	273 - 284
2	2023-2024 Hospital Quality Incentive Program (QIP) Evaluation – *summary page presents on p. 285*	Troy Foster	8:25	285 - 297
3	QI Initiative: Evaluation of 2024 Cervical Cancer Self-Swab Testing Pilot	Brandy Isola & Emily Wellander	8:40	299 - 312
VII.	2023-2024 Perinatal Quality Incentive Program (QIP) Evaluation – *direct questions to Deanna Watson or Amy McCune*			313 - 329
FYI	**Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Feb. 19, 2025**			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Nov. 20, 2024 / 7:32 a.m. – 8:55 a.m. Napa/Solano Room, 1st Floor

Q/UAC has now returned to in-person meetings governed by Brown Act requirements following the Feb. 28, 2023 lifting of California's Public Health Emergency.

Voting Members Present		
Steven Gwiazdowski, MD, FAAP	Brian Montenegro, MD	Michael Strain, PHC Consumer Member
Emma Hackett, MD, FACOG	Meagan Mulligan, FNP-BC	Chris Swales, MD
Brandy Lane, PHC Consumer Member	John Murphy, MD	Jennifer Wilson, MD
Voting Members Absent: Sara Choudhry, MD; Phuong Luu, MD; Robert Quon, MD, FACP; Randolph Thomas, MD		
Partnership *Ex-Officio* Members Present:		Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI		Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Cox, Bradley, DO, Regional Medical Director (Northeast)		Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Devido, Jeff, MD, Behavioral Health Clinical Director		O'Connell, Lisa, Director, Enhanced Health Services
Esget, Heather, RN, BSN, ACM, Director of Utilization Management		Randhawa, Manleen, Senior Health Educator, Population Health
Frankovich, Terry, MD, Associate Medical Director		Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Glickstein, Mark, MD, Associate Medical Director		Ruffin, DeLorean, DrPH, Director of Population Health
Hightower, Tony, CPhT, Associate Director, UM Regulations		Spiller, Bettina, MD, Associate Medical Director
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)		Steffen, Nancy, Senior Director of Quality and Performance Improvement
Jones, Kermit, MD, JD, Medical Director for Medicare Services		Thornton, Aaron, MD, Associate Medical Director
Katz, Dave, MD, Associate Medical Director		Townsend, Colleen, MD, Regional Medical Director (Southeast)
Kubota, Marshall, MD, Regional Medical Director (Southwest)		Watkins, Kory, MBA-HM, Director, Grievance and Appeals
Leung, Stan, Pharm.D, Director of Pharmacy Services		
Partnership *Ex-Officio* Members Absent:		Guillory, Ledra, Senior Manager of Provider Relations Representatives
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer		Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Cotter, James, MD, Associate Medical Director		Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management		Kerlin, Mary, Senior Director of Provider Relations
Guests:		
Beltran-Nampraseut, Athena, Program Manager II, QI (PCP QIP)		Jarrett-Lee, Kevin, Associate Director of Utilization Management
Blake, Jill, Regional Director (Auburn)		Klakken, Vicky, Regional Director (Northwest)
Bontrager, Mark, Sr. Director of Behavioral Health, Administration		Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Brunkal, Monika, RPh, Associate Director, Population Health		Maxwell, Aaron, Director of Transportation Services
Campbell, Anna, Health Policy Analyst, Utilization Management		McCune, Amy, Manager of Quality Incentive Programs, QI
Devan, James, Manager of Performance Improvement, QI		O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Erickson, Leslie, Program Coordinator II, QI (scribe)		Quichocho, Sue, Manager of Quality Measurement, QI
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI		Sackett, Anthony, Program Manager II, QI (CAHPS®)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *None made* Introductions *None made* Approval of Minutes	Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:32 a.m. from the Redding – Airpark office. The Oct. 16, 2024 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • Oct. 8 Internal Quality Improvement (IQI) Committee • Oct. 3 Population Needs Assessment (PNA) Committee • Sept. 23 Quality Improvement Health Equity Committee (QIHEC) • Aug. 29 Member grievance Review Committee (MGRC)	Unanimous Approval of Q/UAC Minutes as presented: Steven Gwiazdowski, MD Second: Chris Swales, MD Unanimous Acceptance of other Minutes: Steven Gwiazdowski, MD Second: Meagan Mulligan, FNP
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Nancy Steffen, Sr. Dir. of Quality and Performance Improvement*	• The locum pilot we have been pursuing over the last several months is designed to bring short term access and a focus to preventative care screenings in measures that we have been struggling with: in HEDIS® (Health Effectiveness and Data Information Set), in particular, we have been focused on well-child visits and cervical cancer screening. This is a money set-aside that we offered to our lower performing QIP provider organizations, four of which accepted this opportunity. They were able to secure a physician vs. a nurse practitioner or other advancing clinician and for a series of weeks, looked at ways they could meet those needs as well as acute visit needs, thereby freeing up providers to see their regular patients who are members. o Two Tribal Health providers participated in this opportunity. o Community Medical Center was offered an extension beyond the initial four-week grant period, simply because they were willing to serve some of our direct Members and focus on child and adolescent well child measure, which is an area of focus in our disparity at present, particularly in the Southeast counties. It is pairing nicely with those providers who were offered capacity enhancement grants, those grant offerings we put forward for those providers who were absorbing our displaced Dignity members earlier this year. We will do a comprehensive evaluation, which will inform how this might be integrated in our ongoing performance improvement work as we address some of our lagging HEDIS measures. • We will continue to update this committee on our mobile mammography program and event days. The program continues to gain efficiencies both with our vendor partner, Alinea, and with our provider network too.	For information only: no formal action required. There were no questions for Nancy.
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• We are pleased to welcome back Chief Executive Officer Sonja Bjork, who has been on extended medical leave. • We are preparing for our annual Department of Health Care Services audit coming in the first weeks of December. DHCS will likely tell us that that we will be accountable for sanctions for county-level performance, instead of region-wide performance. We have many concerns and have pushed back with little success: we will be doing additional analysis to counter their proposal.	There were no questions for Dr. Moore. The "Partnership Advantage" Model of Care will be presented to

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• We do not know as yet how the recent federal election results might effect Medi-Cal and Medi-Cal managed care at the Centers for Medicare and Medicaid Services (CMS). Various trade organization are monitoring developments. • The recent California Medical Association (CMA) House of Delegates meeting focused on rural health and equity and obstetrics access, both of which are high priorities for Partnership. Seven or eight of our Medical Directors attended, together with many of our physician providers. A CMA majority is urban focused, so this was a step in the right direction to put our issues in front of the membership. • "Partnership Advantage," our developing Medicare line of business, is going live Jan. 1, 2026 in eight of our 24 counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano. Preparations are proceeding. We anticipate an initial enrollment of perhaps 3-5,000 members. Note, that although DHCS is mandating that Partnership do this, commercial plans across the country are abandoning Medicare Advantage markets. The financial feasibility is somewhat tenuous: our larger Medi-Cal program should be able to keep it afloat even if it is not profitable for many years.	Q/UAC at its Feb. 19, 2025 meeting. *Meeting postscript:* Dr. Moore's November Medical Directors Newsletter was emailed to Q/UAC clinical members on Nov. 28.
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	2023 PCP QIP Program Evaluation [1] – *direct questions to Athena Beltran-Nampraseut* Grievance & Appeals PULSE Quarterly – *direct questions to Latrice Innes* UM Delegation to Capitated Hospitals – *direct questions to Tony Hightower, CPhT* ***Health Services Policies*** <u>Quality Improvement</u> MCQG1015 – Pediatric Preventive Health Guidelines – ***pulled to audible an addition*** MCQP1021 – Initial Health Appointment MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guideline <u>Utilization Management</u> MCUP3102 – Vision Care MCUP3106 – Waiver Programs MCUP3125 – Gender Dysphoria/Surgical Treatment – ***pulled to audible a deletion*** MCUP3137 – Palliative Care Intensive Program (Adults) <u>Transportation Policies</u> MCCP2016 – Transportation Policy for Non-Emergency Medical (NMT) and Non-Medical Transportation (NMT) MCCP2029 – Emergency Medical Transportation ***Non-Health Services Policy*** <u>Member Services</u> MP300 – Member Notification of Provider Termination of Change in Location	Motion to **approve without the two pulled policies:** Meagan Mulligan, FNP- BC Second: Brian Montenegro, MD *Approved unanimously* Motion to **approve MCQG1015 as amended:** Steven Gwiazdowski, MD Second: Brian Montenegro, MD *Approved unanimously* Motion to **approve MCUP3125 as amended:** Chris Swales, MD Second: Steven Gwiazdowski, MD *Approved unanimously*

[1] As time permitted, Athena also presented her report to Q/UAC. See summation at the end of this document.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Rachel Newman, RN, **pulled MCQG1015 to audible an addition at VI.C.2**. Vaccines for Children (VFC) is not mandatory if a provider site has less than 200 children assigned and refers out to appropriate facilities following the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule. Referrals should be documented in the Electronic Health Record (EHR). Dr. Moore noted that sites with too few patients cannot maintain an inventory of vaccines without it going bad. Both Dr. Moore and Anna Campbell thanked Q/UAC voter Chris Swales, MD, for his pre-review of MCUP3125. At Dr. Swales' suggestion, we are **deleting that policy section that previously recommended 12 continuous months of living in a gender role before reassignment surgery is performed**. This is not a legal requirement.	Next Steps: All policies go to Jan. 8, 2025 Physician Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Health Equity – *Presenter: Mohamed Jalloh, Pharm.D, Director, Health Equity (Health Equity Officer)*		
MCEP6002 – Quality Improvement and Health Equity Committee (QIHEC)	**Changes suggested by senior Health Services leadership at Oct. 8 IQI are now incorporated into this policy revision. Per Nov. 12 IQI,** the Medical Director for Medicare Services and the Director, Enhanced Health Services are now QIHEC members. **Section I. Related Policies.** Added MCNP9002 – Cultural & Linguistic Program Description. **Section VI.B.1.b:** Added that Members are invited to join at the discretion of the co-chairs. **Section VI.B.1.c:** Updated number of official voting members to 9 to 15 to ensure ability to meet quorum threshold and ensure progress of the meeting. **Section VI.B.1.c. 3-4):** Added language mirrors MCNP9022 provisos: QIHEC makes a good faith effort to recruit individuals representing the racial/ethnic, linguistic, gender identity that are represented in our counties. Ideally, the committee is looking to include individuals representing such groups in our network – especially groups that constitute at least 5% of the population at a minimum. Annually, the Health Equity Officer reviews the composition of the committee and will work with committee members to make a good faith effort to meet such thresholds. In alignment with the Consumer Advisory Committee Guiding Principles (see MCND9002, Attachment F), eligible Partnership members, and legal parents, guardians or conservators of an eligible minor (under age 18) Partnership member are eligible to join. **Section VI.B.1.c.6):** Amended to acknowledge that prospective members may be asked to sign Conflict of Interest an Confidentiality agreements. **Section VI.B.6:** Changed meeting frequency from quarterly to every other month due to large number of items that QIHEC will need to review. **Section VI.B.7:** Revised language around the expected content of meeting minutes and the internal departments that receive these minutes and then send them on to DHCS. **Section VI.C.6 & 7:** Added responsibilities to analyze results of Members' grievances around discrimination and any actions taken by the U.S. Equal Employment Opportunity Commission. **Section VI.C.12:** Added that feedback from Partnership's Community Advisory Committee (CAC) will be solicited for continued Diversity, Equity, and Inclusion (DEI) training programs.	There were no questions. Motion to **approve as presented with the additional internal staff:** Brian Montenegro, MD Second: Meagan Mulligan, FNP *Approved unanimously* Next Steps: Jan. 8, 2025 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.C.13: Added that QIHEC will review, provide input, and vote to approve Partnership's Quality Achievement Community Reinvestment plans in the "Cultivating Improved Health" use category if the Health Plan is subject to the quality achievement community reinvestment requirement by DHCS. Dr. Jalloh went through the synopsis. In future, QIHEC may go from meeting every other month to meeting monthly to meet DHCS expectations around health equity work. Note: after the meeting packet was distributed, we added our Tribal Health Liaison, our Associate Director for Transportation and our PMO director as standing QIHEC members.	
Policy Owner: Population Health – *Presenter: Hannah O'Leary, MPH, Manager of Population Health*		
MCNP9006 – Doula Services Benefit	Changed instances of "PHC" to "Partnership, and Partnership URL changed to the current standard (PartnershipHP.org), small grammar changes. Various parts removed that are no longer relevant or are best conveyed in other policies. (See Related Policies section.) **Section I:** added MCND9002 Cultural and Linguistic Program Description to Related Policies. **Section VI.A.2:** added that doulas are "trained birth workers." **Section VI.E.2.d.1:** added "The extended postpartum visits are billed in 15-minute increments, up to three hours, up to two visits per pregnancy per individual, provided on separate days." **Section VI.E.3.b:** added "the LPHA can note the medical need for the member or include chart notes that specify the need for additional visits." **Section VI.H.3:** added "1.Refer to sections VI.E.2. for a description of doula services authorized under the DHCS standing recommendation and section VI.E.3. for services that require prior authorization." **Section VI.I.2:** added "Doulas are not prohibited from teaching classes that are available at no cost to Members to whom they are providing doula services." **Section VI.K.4.a:** added "Doulas must submit claims with diagnosis and procedure codes as outlined by DHCS. Please refer to Attachment B for the list of codes. **Section VI.K.4.b:** added "Partnership will submit data related to doula services utilization and provider network per DHCS requirements." **New Attachment B:** Doula Crosswalk Coding Information This attachment adds a resource for doulas looking for DHCS diagnosis codes. Doulas are required to include a DHCS diagnosis code on their claims.	There were no questions. Motion to **approve as presented:** Chris Swales, MD Second: Meagan Mulligan, FNP *Approved unanimously* Next Steps: Jan. 8, 2025 PAC
Policy Owner: Behavioral Health – *Presenter: Mark Bontrager, Senior Director, Behavioral Health*		
MCUP3028 – Mental Health Services	**This policy was updated to include changes per APL 22-029 Revised, Dyadic Services & Family Therapy Benefit.** **Section I:** Policy MCQG1015 – Pediatric Preventive Health Guidelines was added as a Related Policy **Section III. B. – D.:** Definitions were added for Dyad, Dyadic Services Benefit, and Managed Behavioral Healthcare Organization. **Section VI.A.4.d.4):** Language around our closed loop referral process in response to a DHCS Focused Audit	Motion to **approve as presented:** Meagan Mulligan, FNP Second: Brian Montenegro, MD *Approved unanimously*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.J.: This new section was added to describe how Partnership covers family therapy. **Section VI.N.3.:** This paragraph was added to explain how Partnership will execute MOUs with County Mental Health Plans for the purpose of sharing clinical data in order to better coordinate care of Members, improve quality and meet the requirements of the Behavioral Health Quality Incentive Program (BHQIP). **Section VI.O.:** This new section was added to describe the Dyadic Services Benefit. **Section VII.N. and O.:** Two new References were added for APL 22-029 Revised: Dyadic Services & Family Therapy Benefit (03/20/2023) and California Welfare and Institutions Code section 14132.755, Dyadic Behavioral Health Visits Mark went through the synopsis, clarifying that the added dyad definition refers to child/parent caregiver. The closed looped referral language now reflects that Partnership must ensure that, when making a referral to a county-level system of care for specialty mental health or SUD services, Partnership needs to ensure there is another appointment set in that other system of care and that we know the results of that appointment. Section VI.4.d.4, notes that if Partnership is unable to confirm with the other system of care that the appointment was fulfilled, we will seek confirmation with the Member. We note that family therapy is a covered benefit. We add a lengthy description of the dyadic services benefit, which is really a behavioral health well-child visit that is to occur on the same schedule as a medical well-child visit going forward. It is a bit of a cut and paste from the APL but it is now contained herein. Rachel Newman, RN, noting that the Pediatric Preventive Health Guidelines had been added to the Related Policies list, asked if the Adult guidelines should be added as well. Mark said no as this dyadic benefit is only available to members aged 20 and below and their caregiver. There is no applicability to adults, he said. Jeff Ribordy, MD, and Mark Netherda, MD, concurred.	Next Steps: Jan. 8, 2025 PAC
MCUP3101 – Screening and Treatment for Substance Use Disorders	**Section IV. Attachments:** Policy attachments C. and D. were Archived. Instead, the requirements for Brief Behavioral Counseling Intervention/ Referral can be found in the main MCUP3101 policy document. Due to this change, Attachment E. became Attachment C. **Section VI.A.3.b.:** Recommended ICD 10 codes for medical specialists providing office visits for SUD treatment were updated to F11.xx or F10.xx. to avoid the requirement for a RAF. **Section VI.B.3.a. and VI.C.8.a. :** Deleted the word "outpatient." **Section VI.C.3.c. :** Deleted part of this paragraph describing the Application to be a Contracted Brief Behavioral Counseling Intervention/ Referral to Treatment Provider. Attachments C and D regarding the application process have been Archived. **Section VI.C.5. and 5.e. and 5.e.1) :** Deleted the word "Contracted" Mark explained that VI.A.3.b. expands coding that can be used to bill Medication Assisted Treatment (MAT) without the requirement of a RAF. We eliminated the specific 10.2 and 11.2 for alcohol dependence and opioid dependence and allowed other subcategories of those classifications to remove any potential RAF needs for MAT services. The reference to contracted brief behavioral health providers and the subsequent Attachment C associated with that is removed as we never had anyone	There were no questions. Motion to **approve as presented:** Meagan Mulligan, FNP Second: Brian Montenegro, MD *Approved unanimously* Next Steps: Jan. 8, 2025 PAC

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	exercise contracting as a brief behavioral health intervention provider. Currently, primary care providers and their staff can bill for a brief intervention under an H code. Dr. Moore said that when Screening and Treatment for SUD was first covered by the state maybe a decade ago, the county folks thought they could potentially bill Partnership for this little slice of services and get reimbursed; however, the amount of effort it takes to bill for a relatively few bucks is not worth it.	
Policy Owner: Utilization Management – *Presenter: Colleen Townsend, MD, Regional Medical Director (Southeast)*		
MCUP3131 – Genetic Screening & Diagnostics	Minor changes in the main policy: **VII. A.** Updated CDC hyperlink in References **IX:** Updated "Position Responsible for Implementing Procedure" to say "Chief Health Services Director." **Attachment A Updates:** **Code 81220:** Added ICD codes E84, X38.49 and Z31.5 as criteria **Code 81221:** Changed to require No TAR per MD review and cost <$500 **Code 81222:** Changed to require No TAR per MD review and cost <$500 **Code 81232:** New coded added for DPYD gene analysis. TAR is required with criteria that Patient had severe and unexpected toxicity (such as myelosuppression, mucositis, diarrhea, neurotoxicity, cardiotoxicity) during treatment with Fluorouracil or Capecitabine chemotherapy **Code 81259:** Changed to require No TAR per MD review and cost <$500 **Codes 81272 and 81273:** Added ICD codes D47.01 and D47.02 as criteria **Code 81336:** Changed to require No TAR per MD review and cost <$500 **Code 81337:** Changed to require No TAR per MD review and cost <$500 **Code 81405:** Added SLSLC22A5 gene (for carnitine deficiency or carnitine uptake defect) as criteria: Allowable when the newborn screen is positive for low carnitine levels or when there is clinical suspicion **Code 81406:** Added DSP gene as criteria: The patient has clinical features suspicious for Arrhymogenic Right Ventricular Myopathy ICD 10 code I42. **Code 81408:** Added COL1A1, COL1A2 genes (Osteogenesis Imperfecta) as criteria with ICD code Q78 **Code 81412:** New coded added for Ashkenazi Jewish-associated disorders. A TAR is required with documented criteria to include Patient is considering pregnancy or is currently pregnant and Patient reports they are of Ashkenazi Jewish descent. **Code 81420:** New statement added to say "Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity." **Codes 81457, 81458 and 81459:** New codes added for Solid Organ Neoplasm genomic sequence analysis panel. A TAR is required with various criteria stated for both somatic and germline testing. **Codes 81462:** New code added for Solid Organ Neoplasm genomic sequence analysis panel. A TAR is required with criteria to include The patient has a diagnosis of on-small cell lung cancer, and The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible, and Management is	There were no questions. Motion to **approve as presented:** John Murphy, MD Second: Emma Hackett, MD *Approved unanimously* Next Steps: Jan. 8, 2025 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	contingent on the test results. **Code 81507:** New statement was added to say "Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity." **Codes 81517:** New code added for Liver disease, analysis of 3 biomarkers. No TAR is required. No Criteria listed. **Attachment C Updates:** **Code 0014M:** Deleted effective 01/01/2024 **Code 0204U:** Deleted effective July 2024 **Code 0242U:** Criteria for this code updated to include Hormone receptor-positive, Human Epidermal Growth Factor Receptor 2 (HER2)-negative breast cancer. Criteria removed: "~~The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible~~." **Code 0276U:** Code description updated to remove these words: "~~Hematology (inherited thrombocytopenia~~)" **Code 0327U:** : New statement added to say "Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity." **Code 0329U:** Criteria for this code updated with somatic testing guidelines. **Code 0331U:** Deleted. **Code 0334U:** Criteria for this code updated with somatic testing guidelines. **Code 0337U:** Deleted **Code 0338U:** Deleted **Code 0342U:** Deleted **Code 0343U:** Deleted **Code 0344U:** Deleted **Code 0353U:** Deleted **Code 0354U:** Deleted **Code 0379U:** Criteria updated with somatic testing guidelines. **Code 0391U:** Criteria updated with somatic testing guidelines. **Code 0397U:** Deleted **Code 0408U:** New code added for Oncology (solid tumor), DNA (80 genes) and RNA (36 genes), by next-generation sequencing from plasma, including single nucleotide variants, insertions/deletions, copy number alterations, microsatellite instability, and fusions, report showing identified mutations with clinical actionability. A TAR is required. **Code 0409U:** New code added for Oncology (solid tumor), DNA (80 genes) and RNA (36 genes), by next-generation sequencing from plasma, including single nucleotide variants, insertions/deletions, copy number alterations, microsatellite instability, and fusions, report showing identified mutations with clinical actionability. A TAR is required.	

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	Code 0448U: New code added for Oncology (lung and colon cancer), DNA, qualitative, next-generation sequencing detection of single-nucleotide variants and deletions in EGFR and KRAS genes, formalin-fixed paraffin-embedded (FFPE) solid tumor samples, reported as presence or absence of targeted mutation(s), with recommended therapeutic options. A TAR is required. **Code 0471U:** New code added for Oncology (colorectal cancer), qualitative real-time PCR of 35 variants of KRAS and NRAS genes (exons 2, 3, 4), formalin-fixed paraffin-embedded (FFPE), predictive, identification of detected mutations. A TAR is required. **Code 0473U:** New code added for Oncology (solid tumor), next-generation sequencing (NGS) of DNA from formalin-fixed paraffin-embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-mutation burden. A TAR is required. **Code 0475U:** New code added for Hereditary prostate cancer-related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for prostate cancer. A TAR is required. **Code 0488U:** New code added for Obstetrics (fetal antigen noninvasive prenatal test), cell-free dna sequence analysis for detection of fetal presence or absence of 1 or more of the rh, c, c, d, e, duffy (fya) or kell (k) antigen in alloimmunized pregnancies, reported as selected antigen(s) detected or not detected. A TAR is required. **Code 0494U:** New code added for Red blood cell antigen (fetal rhd gene analysis), next-generation sequencing of circulating cell-free dna (cfdna) of blood in pregnant individuals known to be rhd negative, reported as positive or negative. A TAR is required. Dr. Townsend reiterated that the policy itself has only minor changes. Most changes have to do with the addition of codes that still require a TAR and the deletion of those that no longer require a TAR. Partnership makes every attempt to avoid unnecessary denials when the evidence clearly supports the use of particular genetic tests in workups, she added. Dr. Townsend thanked Anna Campbell her work on this policy.	
VI. Presentations		
Grand Analysis: Member Experience MY 2023 / RY 2024 *Anthony Sackett, Program Manager II (CAHPS®)* and	The Member Experience Grand Analysis (MEGA) is required for NCQA accreditation. Anthony reviewed the highlights of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores, and key learnings that came out of the regulated survey and the non-regulated survey put into the field to drill down on some insights in the adult population only. Kory recounted MY 2023 grievances and appeals and second-level grievance numbers, data that does not encompass the 10 counties Partnership expanded into in CY 2024. The five measures of the patient/member experience are spread across three categories: getting care (access), satisfaction with plan physicians, and satisfaction with the plan and plan services, and are essentially what NCQA looks at when they are rating our patient experience Star rating. There are two access composites: these scores only represent the summary rates, the most favorable outcomes, so when the question is asked it's "always" or "usually." Seventy-four percent of adult respondents "always or usually" got needed care, while 68.1% similarly responded to	

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Kory Watkins, MBA-HM, Director, Grievance & Appeals	"getting care quickly;" still, these measures slightly underperformed from the previous year regulated survey. "Rating of personal doctor" garnered the highest possible rating of 9 to 10 with 70% of respondents, a 3.1% bump above last year, putting us at the 64th percentile in HEDIS QI benchmark rankings. ("Rating of specialists" was pulled out of the measure set.) The highest negative summary rate change came in the "rating of health care," which experienced a -9.4% drop from last year's regulated adult survey. Despite the declines, the overall health plan rating remains at 3.5 (out of 5) Stars for the second year in a row. John Murphy, MD, asked whether the HEDIS® Quality Compass benchmarks were commercial or Medicaid or combined? Manager of Quality Measurement Sue Quichocho responded that the benchmarks are nationwide for Medicaid Anthony said that while the regulated survey was underway, the team composed of QI, Pop Health, and other department staff collaborated in a drill-down survey look at additional data sources to assess "benefit literacy." They discovered theme related questions specific to Medi-Cal covered benefits through Partnership or State-covered, for example, Denti-Cal or Pharmacy. Nearly one-half (47%) of respondents rated their understanding of benefits as "fair" or "poor." Where did they go to seek understanding? A third (35.7%) sought out provider or office staff, followed by contacting Partnership directly (29.1%), followed by the self-serve modality between the website and member handbook. These relate to overall health care delivery, so when we think about influence, these questions relate. Of note, this is the first year that we did the adult survey non-regulated and the combined completes; both the regulated and non-regulated together totaled almost 1,200, so we believe this population provided us some new key learnings. (For a complete list of all those, reference Appendix C.) The Child (not being submitted to NCQA) performed better than did the Adult in several of the measures, except rating of health care, so there was a similarity in satisfaction. (Anthony encouraged everyone to look at the appendices for the drivers behind the data.) "Getting care quickly" saw a +2.6% bump above MY 2022. In general, when we think about health equity, adult and child members considering their overall mental and physical health between "fair" and "good" are essentially scoring lower satisfaction than the other members within the survey populations. American Indian or Alaskan Natives are expressing dissatisfaction across several measures. Kory presented grievance data comparing CY 2023 to CY 2022. Our grievances in this grand analysis are classified into the five NCQA categories: access, attitude/service, billing/financial, quality of care and quality of provider office. We are measuring those grievances using the average Partnership membership and coming to grievances per 1,000 members. That measurement gives us a good benchmark on categories and against other plans. If a threshold is not met, that means we had more than a 10% increase in filings. Transportation issues, including rude drivers or transportation making folks late to appointments, had much to do with the attitude/service threshold not being met, Kory noted. For quality of care, treatment plan disputes is probably our biggest category. Overall, 2023 grievances jumped 28.5% from 2022. The biggest driver in the increase was Transportation: 42% of 2023 grievances filed were Transportation related, compared to 22% in 2022. Appeals and Second Level Grievances decreased from 1.19 to 1.02 in 2023. We do very few second-level grievances, and these will be going away next year. (The nine second-level cases in 2023 "quality of care" primarily consist of treatment plan disputes.) Otherwise, we were under the 10% threshold change and thereby "met" the other four NCQA categories' appeals thresholds. Anthony said complete details of the interventions for the past fiscal year can be found in appendices A&B. For FY 2024-2025, we're really looking at addressing access through understanding the primary care and specialty care landscapes and expanding the "your partner in health" branding campaign. We are proactively looking at G&A data and focusing on service and attitude in Transportation. Dr. Moore noted that there were some important findings in the drill down survey and asked Anthony to summarize highlights. Anthony again mentioned benefit literacy and tackling the instances where members got misinformation and had to call the Plan. This is not showcased in the	

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	NCQA ME 7 but we are working with Member Services and Pop Health on some input from the annual leadership retreat, surveying line staff across both departments and developing a triage list of the most common questions asked throughout the year. We hope to evaluate and recommend how to standardize communications (both to members and the provider network) The other thing of interest is the members do not mind waiting long in the waiting room; they just want to get into care when they need it. Nancy Steffen commented that one of the important things to note is how many members didn't understand their benefits. When we asked "who do you seek help from"?, they trust their provider to help them. We need to help our provider network help our members navigate. Dr. Murphy noted that, currently, about 1 in 4 or 5 are actually using the member website. Have we seen that notching up over the years as the digital divide somewhat narrows, or are we finding that just 3 out of 4 members just don't go to the website? Anthony said we could take this question back to our Communications department where they do track the analytics of page hits and visits. We are currently working on restructuring our website and the method to deliver member communication, whether that is through the portal, texting and different communication modalities to help. Dr. Murphy added that 1 out of 3 are calling Partnership, "which is a lot of call volume. It's interesting to see how people contact service providers in their lives." (He noted we can't call Google or Meta.) Dr. Netherda read out Dr. Dave Katz's chat composed as this discussion ensured. Dr. Katz suggested that in his primary care practice experience in urban Sacramento, many patients he sees are not literate either in English or the language of their birth or computer literate or have ready access to the Internet. If you are not literate, you will not go to a website. You are going to call someone. Also, we all know that age plays a huge part in this. As our younger people age up and become more used to that website, we'll see that change over time. Dr. Murphy recommended looking at the literature regarding patient portal utilization in the safety net. Anthony said we are looping in members of the CAHPS committee and looking at multiple modalities to communicate with the members. Appendix A references member informative sessions being led by our Member Services department. Dr. Katz commented that if a provider attempts to help a member by looking at our website, some answers may be hard to interpret. He recommends posting a facts sheet that answers common questions. Anthony said we are looking at ways to better utilize info graphics to streamline our website and speak more plainly too. Population Health Director DeLorean Ruffin asked if we are ever assessed on utilization of how we are promoting to our members the use of the portal? Anthony responded we do track utilization and that "we got a nice bump when we expanded to the 10 counties." Dr. Moore concluded that our current website absolutely fails at clearly describing the benefits. Even many Partnership staff would have a hard time finding some answers. The 2025 Member Handbook, which is DHCS mandated, however, "is far superior" to any he has seen since being at Partnership. Our website needs improvement, and we have a whole project focused on that; however, if our goal is that everybody understands everything about benefits, we are going to fail. Dr. Moore expects the Transportation benefit will be one of the top three to address because even many of our providers don't know about it. The Provider Directory is on the list of things that need to be improved as well.	
Grand Analysis: Network Access MY 2023	A scheduling miscommunication prohibited this presentation. Please refer to the materials included in the Q/UAC packet and to the draft Nov. 7 Internal Quality Improvement (IQI) Committee minutes for more information.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
2023 PCP QIP Program Evaluation *Athena Beltran-Nampraseut, CPhT, Program Manager II, QI*	The PCP QIP runs on a calendar year: Jan. 1 – Dec. 31. We had a total of 11 clinical measures divided among three main categories: chronic disease management, preventative screening and pediatric access. The measure assignment varies depending on the practice type. Our clinical targets are set at the 75th percentile for full points and the 50th percentile for partial points and also based on the Quality Compass benchmarks, the same benchmarks mentioned earlier in the CAHPS presentation. The exception to this rule is the colorectal measure: we instead use our own internal data to create our targets. We chose to use the 50th percentile for full points and the 25th percentile for partial points. We had (four) non-clinical measures divided among two measure categories: appropriate use of resources and access and operations. The fifth, Patient Experience, is a stand-alone measure, with two different options of how a provider can earn points: the CG CAHPS with points on access and communication or the survey option, based on a two-part submission. The Unit-of-Service measure set is separate from the core measure set so its payment methodology is different and calculated outside of the core measurement set. Participation is optional and incentives are earned by submission to the inbox: the exceptions are blood lead screening, part two of the dental varnish, and tobacco use screening. The incentives for these three are based on claims data. For MY 2023, we moved diabetes management: retinal eye exams, and the PCP office visits from MY 2022 monitoring status into the core measurement set. For the UOS measures, we retired both the alcohol misuse screening and the initial health assessment. With MY 2023, we implemented a new payment methodology, the equity adjustment, the intent of which is to make out incentives fair across the network. There is a gateway to these adjustments: a provider must have at least 100 assigned members and the core adjustment is made up of four factors: acuity of patient panel; socio-demographic risk at patient level rolled up to PCP site level; site difficulty in recruiting PCP physicians, and lower-than-average baseline per visit resources available to PCP. Disaster adjustments and pediatric access adjustments can also apply. Looking at plan-wide performance year-over-year (2021-2023), we see seven of the 11 2023 measures had an increase in performance over 2022. The top three measures with the largest relative change were immunizations for adolescents (+7.15% increase), followed by HbA1c good control (+ 5.99%) and breast cancer screening (+4.06%). WCV – first 15 months and child and adolescent WCV also improved (+3.92% and +4.04% respectively). More providers in 2023 than in 2022 earned partial points for both pediatric access clinical measures. Cervical cancer screening, breast cancer screening and immunization for children also had a higher percentage of providers earning partial points compared to the prior MY. So too Diabetes – HbA1c. More providers in 2023 than in 2022 earned full points in these same measures. The PCP QIP also offers relative improvement (RI) to further incentivize. A site must meet 50th percentile targets and achieve a RI of 10% or more on an existing clinical measure. Athena then went over a graph which charted partial points, full points, and RI per clinical measure plan wide: 26% of providers achieved full points in the child and adolescent WCV measure based on RI, increasing YoY performance. Looking at the lower end of the RI scale, only about 6% of our providers earned full points based on RI in the cervical cancer screening measure; 53% of our providers earned no points for this measure in 2023. We saw a decline in YoY performance for the non-clinical domain measures. Note that we do not apply RI to our non-clinical measures. Looking at the PCP Office Visits and the Risk-adjusted Readmission (RAR), however, 72% and 69% of participants, respectively, achieved full points. This is great to report because Risk-adjusted Readmission is considered one of our most difficult non-clinical domain measures.	

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	There were a total of nine UOS measures, each with its own incentive payout amount. In MY 2023, we had higher payouts than in 2022 for three of these measures: health equity, dental fluoride varnish, and tobacco use screening. But we have had less than 30% provider participation in each measure YoY, 2021-2023. Advance Care Planning continues to have the highest participation rate YoY for all UOS measures and had the largest payout in 2023. For 2023, we had a total incentive payout of $38.5M. With the equity adjustment applied to our methodology the baseline PMPM rate was $4 and the weighted average earned PMPM was $7.08. Eight of the 14 counties earned a higher payout in 2023 than they did in 2022. Plan-wide, the payout was $182,726 above 2022 payout. Humboldt, Lake and Napa saw the largest increase in payout 2023 over 2022, respectively earning between $526 – 900K more in 2023 than in 2022. Sonoma, Marin, and Yolo had a decrease in payouts. In summary, 2023 programmatic changes were the addition of one new clinical measure: diabetes retinal eye exams, and one non-clinical measure: PCP office visits; the retirement of two UOS measures: alcohol misuse screening and IHA; and equity adjustments. Seven of our 11 clinical measures saw improvement from prior measurement year. Four clinical measures ended above the 50th percentile HEDIS® benchmark and two above the 75th percentile HEDIS® benchmark. Based on MY 2023 and 2024 performance and the updated guidelines, we have **the following recommendations for MY 2025**: • Expand BCS age range from 50-75 years of age range to 40-75 year of age. • Add new clinical measures: chlamydia screening, WCV in the first 15-30 months of life, topical fluoride in children, and reduction of Inequity adjustment • New UOS measure: academic detailing • Replace non-clinical RAR with Follow-up within 7 days after Hospital Discharge measure • Update Peer-led and Pediatric group visit UOS measures • Raise thresholds back to 75th percentile for partial points and 90th percentile for full points. **The Physician Advisory Committee (PAC) approved this 2025 measure set on Oct. 9.** Dr. Murphy had no questions. “We just appreciate the program,” he said. “The motivation has been helpful. We appreciate the methodology and wish more health plans did the same.”	
VIII. **Adjournment** – Q/UAC adjourned at 8:55 a.m. HAPPY DECEMBER HOLIDAYS! Q/UAC next meets at 7:30 a.m. Wednesday, Jan. 15, 2025.		

Respectfully submitted by: Leslie Erickson, Program Coordinator II, QI

Signature of Approval: _____ Date: _____

Robert Moore, MD, MPH, MBA
Chief Medical Officer and Committee Chair

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Nov. 12, 2024 / 1:30 – 3:25 PM

Members Present:
Andrews, Leigha, MBA, Regional Director, Southeast
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI
Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services
Campbell, Anna, Policy Analyst, Utilization Management
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Hightower, Tony, CPhT, Associate Director, UM Regulations
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Klakken, Vicki, Regional Director, Northwest
Kubota, Marshall, MD, Regional Medical Director – Southwest
Leung, Stan, Pharm.D, Director of Pharmacy Services
Matthews, Richard "Doug," MD, Regional Medical Director – Chico
Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Randhawa, Manleen, Senior Health Educator, Population Health
Ruffin, DeLorean, DrPH, MPH, Director of Population Health

Members Absent:
Ayala, Priscila, Director, Network Services
Bjork, Sonja, JD, Chief Executive Officer
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MHA, MBA, Director of Quality Management, Quality Improvement
Brunkal, Monika, RPh, Assoc. Dir., Population Health
Davis, Wendi, Chief Operating Officer
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Kerlin, Mary, Senior Director, Provider Relations
Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Sharp, Tim, Regional Director, Northeast
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Turnipseed, Amy, Senior Director of External and Regulatory Affairs
Villasenor, Edna, Senior Director, Member Services and G&A

Guests:
Arrazola, Kelcie, Provider Education Specialist, Provider Relations
Beltran-Nampraseut, Athena, CPhT, Program Manager, PCP/QIP
Bikila, Dejene, Manager of Data Science, Finance
Blake, Jill, Regional Director, Auburn
Bontrager, Mark, Senior Director of Behavioral Health, Health Services
Chebolu, Radha, Senior Health Data Analyst II, Finance
Clark, Kristen, Manager of Quality & Training, Member Services
Devan, James, Manager of Performance Improvement, QI
Donahue, Celena, Improvement Advisor, QI (Eureka)
Ducay, Robert, Senior Director of Fiscal Policy & Strategy, Finance
Erickson, Leslie, Program Coordinator II, QI (scribe)
Hanusiak, Kenzie, Senior Manager of Regulatory Affairs & Compliance
Harris, Matthew, Provider Education Specialist, Provider Relations
Harris, Vander, Senior Health Data Analyst I, Finance
Jamali, Shahrzad, Improvement Advisor, QI (Chico)
Johnson, Krystal, County Child Welfare Liaison, Behavioral Health
Kung, Jen, Senior Health Data Analyst II, Finance
Lee, Donna, Manager of Claims, Claims
Maxwell, Aaron, Director of Transportation Services
McCune, Amy, Manager of Quality Incentive Programs, QI
Moore, Jordan, Provider Education Specialist, Provider Relations
Moraghebi, Roudabeh, Manager of Health Analytics, Finance
Nakatani Phipps, Stephanie, Manager of PR Representatives, Provider Relations
Nguyen, Tom, Manager of Health Analytics, Finance
O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Russ, Senior Health Data Analyst I, Finance
Robertello, Kimberly, Senior Medicare QI Program Manager, QI
Roberts, Dorian, Improvement Advisor, QI (Redding)
Romero, Liz, Improvement Advisor, QI (Fairfield)
Sackett, Anthony, Program Manager II, QI (MEGA)
Selig, Barbara, Manager of Quality Improvement Programs, QI
Sivasankar, Shivani, Senior Data Scientist, Finance
Stark, Rebecca, Regional Director, Chico
Thomas, Andrea, Project Manager I, QI
Thomas, Penny, Sr. Health Data Analyst, Finance
Townsend, Colleen, MD, Regional Medical Director, Southeast
Trosky, Renee, Manager of PR Compliance, Network Services
Vaisenberg, Liat, Associate Director of Health Analytics, Finance
Vance, Brooke, Program Manager I, Network Services
Watkins, Kory, MBA-HM, Director of Grievance & Appeals
Wellander, Emily, Improvement Advisor, QI (Santa Rosa)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Introductions Approval of Minutes	Medical Director for Quality and IQI Vice Chair Mark Netherda, MD, remotely attended and called the meeting to order at 1:31 p.m. in the vacation absence of Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA. Latrice Innes corrected the Oct. 8 IQI minutes as follows: it was MP300, and not CGA022, that was pulled from the consent calendar for discussion. *Acknowledgement and Acceptance of draft meeting minutes of the* • Aug. 29 Member Grievance Review Committee (MGRC) • Oct. 3 Population Needs Assessment (PNA) Committee	Motion to approve IQI Minutes **as corrected:** Latrice Innes Second: Lisa O'Connell, MHA Motion to accept other minutes: Marshall Kubota, MD Second: Lisa O'Connell, MHA
II. Old Business – Returning from Oct. 8 IQI		
Policy Owner: Health Equity – *Presenter: Mohamed "Moe" Jalloh, Pharm.D, Director of Health Equity/Health Equity Officer*		
MCEP6002 – Quality Improvement and Health Equity Committee (QIHEC)	**Changes suggested by senior Health Services leadership at Oct. 8 IQI are now incorporated into this policy revision.** **Section I. Related Policies.** Added MCNP9002 – Cultural & Linguistic Program Description. **Section VI.B.1.b:** Added that Members are invited to join at the discretion of the co-chairs. **Section VI.B.1.c:** Updated number of official voting members to 9 to 15 to ensure ability to meet quorum threshold and ensure progress of the meeting. **Section VI.B.1.c. 3-4):** Added language mirrors MCNP9022 provisos: • QIHEC makes a good faith effort to recruit individuals representing the racial/ethnic, linguistic, gender identity that are represented in our counties. Ideally, the committee is looking to include individuals representing such groups in our network – especially groups that constitute at least 5% of the population at a minimum. Annually, the Health Equity Officer reviews the composition of the committee and will work with committee members to make a good faith effort to meet such thresholds. • In alignment with the Consumer Advisory Committee Guiding Principles (see MCND9002, **Attachment E**), eligible Partnership members, and legal parents, guardians or conservators of an eligible minor (under age 18) Partnership member are eligible to join. **Section VI.B.1.c.6):** Amended to acknowledge that prospective members may be asked to sign Conflict of Interest an Confidentiality agreements. **Section VI.B.6:** Changed meeting frequency from quarterly to every other month due to large number of items that QIHEC will need to review. **Section VI.B.7:** Revised language around the expected content of meeting minutes and the internal departments that receive these minutes and then send them on to the Department of Health Care Services (DHCS). **Section VI.C.6 & 7:** Added responsibilities to analyze results of Members' grievances around discrimination and any actions taken by the U.S. Equal Employment Opportunity Commission. **Section VI.C.12:** Added that feedback from Partnership's Community Advisory Committee (CAC) will be solicited for continued Diversity, Equity, and Inclusion (DEI) training programs. **Section VI.C.13:** Added that QIHEC will review, provide input, and vote to approve Partnership's Quality Achievement Community Reinvestment plans in the "Cultivating Improved Health" use category if the Health Plan is subject to the quality achievement community reinvestment requirement by DHCS.	Motion to **approve as amended**: Doug Matthews, MD Second: Colleen Townsend, MD Next Steps: Nov. 20 Quality/Utilization Advisory Committee (Q/UAC) Jan. 8, 2025 Physician Advisory Committee (PAC)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Dr. Jalloh went through the synopsis, adding that although QIHEC now meets every other month, it might meet monthly as we near National Committee for Quality Assurance Health Equity Accreditation (NCQA HEA). Quarterly impact reports will be submitted to the State. Anna Campbell asked whether Enhanced Health Services (EHS) should be represented on QIHEC. Dr. Netherda noted that perhaps Kermit Jones, MD, should also sit on QIHEC. Dr. Jalloh agreed. **The Director of EHS** and **the Medical Director for Medicare Services are now added to the policy's staffing list.**	
III. New Business Consent Calendar (Committee Members as applicable)		
(Old Business) Member Services' MP300 – Member Notification of Provider Termination of Change in Location *returned from October* Grievance & Appeals' PULSE Quarterly UM delegation to Capitated Hospitals ***Health Services Policies*** <u>Quality Improvement</u> MCQG1015 – Pediatric Preventive Health Guidelines – ***Anna Campbell pulled to suggest edit*** MCQP1021 – Initial Health Appointment MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guideline <u>Utilization Management</u> MCUP3102 – Vision Care MCUP3106 – Waiver Programs MCUP3125 – Gender Dysphoria/Surgical Treatment MCUP3137 – Palliative Care Intensive Program (Adult) <u>Transportation</u> MCCP2016 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) MCCP2029 – Emergency Medical Transportation ***Non-Health Services Policies*** <u>Credentialing</u> MPCR100 – Credential and Re-credential Decision Making Process MPCR102 – Provider Directory Accuracy MPCR300 – Physician Credentialing and Re-credentialing Requirements Anna Campbell **pulled MCQG1015 to delete MPCP2002** (California Children's Services) from the Related Policies section as all 24 Partnership counties will be under the Whole Child Model for California Children's Services (MCCP2024) and MPCP2002 will be archived, effective Jan. 1, 2025.	The Consent Calendar but for MCQG1015 was **approved as presented:** Marshall Kubota, MD Second: Lisa O'Connell, MHA Motion to approve MCQG1015 **as amended:** Marshall Kubota, MD Second: Lisa O'Connell, MHA <u>Next Steps:</u> QI, UM, and Transportation policies will go to the Nov. 20 Quality/ Utilization Advisory Committee (Q/UAC) and the Jan. 8, 2025 Physician Advisory Committee (PAC) *Post-meeting Note: Credentialing policies passed the Credentials Committee on Nov. 13.*
IV. New Business – Discussion Policies		
Policy Owner: Population Health Management – *Presenter: Hannah O'Leary, MPH, Manager of Population Health*		
MCNP9006 – Doula Services Benefit	Changed instances of "PHC" to "Partnership, and Partnership URL changed to the current standard (PartnershipHP.org), small grammar changes. Various parts removed that are no longer relevant or are best conveyed in other policies. (See Related Policies section.)	Motion to **approve as presented**: Marshall Kubota, MD

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section I: added MCND9002 Cultural and Linguistic Program Description to Related Policies. **Section VI.A.2:** added that doulas are "trained birth workers." **Section VI.E.2.d.1:** added "The extended postpartum visits are billed in 15-minute increments, up to three hours, up to two visits per pregnancy per individual, provided on separate days." **Section VI.E.3.b:** added "the LPHA can note the medical need for the member or include chart notes that specify the need for additional visits." **Section VI.H.3:** added "1.Refer to sections VI.E.2. for a description of doula services authorized under the DHCS standing recommendation and section VI.E.3. for services that require prior authorization." **Section VI.I.2:** added "Doulas are not prohibited from teaching classes that are available at no cost to Members to whom they are providing doula services." **Section VI.K.4.a:** added "Doulas must submit claims with diagnosis and procedure codes as outlined by DHCS. Please refer to Attachment B for the list of codes. **Section VI.K.4.b:** added "Partnership will submit data related to doula services utilization and provider network per DHCS requirements." **New Attachment B:** Doula Crosswalk Coding Information This attachment adds a resource for doulas looking for DHCS diagnosis codes. Doulas are required to include a DHCS diagnosis code on their claims. Mark Netherda, MD, commented that the language in the VI.I.2 addition seemed awkward. Hannah noted that it is drawn from the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024, and Dr. Netherda said he had no objection to it remaining as worded. There were no questions.	Second: Colleen Townsend, MD Next Steps: Nov. 20 Q/UAC Jan. 8, 2025 PAC
Policy Owner: Behavioral Health – *Presenters: Anna Campbell, UM Policy Analyst,* and *Mark Bontrager, Senior Director of Behavioral Health*		
MCUP3028 – Mental Health Services	**This policy was updated to include changes per APL 22-029 Revised, Dyadic Services & Family Therapy Benefit.** **Section I:** Policy MCQG1015 – Pediatric Preventive Health Guidelines was added as a Related Policy **Section III. B. – D.:** Definitions were added for Dyad, Dyadic Services Benefit, and Managed Behavioral Healthcare Organization. **Section VI.J.:** This new section was added to describe how Partnership covers family therapy. **Section VI.N.3.:** This paragraph was added to explain how Partnership will execute MOUs with County Mental Health Plans for the purpose of sharing clinical data in order to better coordinate care of Members, improve quality and meet the requirements of the Behavioral Health Quality Incentive Program (BHQIP). **Section VI.O.:** This new section was added to describe the Dyadic Services Benefit. **Section VII.N. and O.:** Two new References were added for APL 22-029 Revised: Dyadic Services & Family Therapy Benefit (03/20/2023) and California Welfare and Institutions Code section 14132.755, Dyadic Behavioral Health Visits Anna noted that the dyadic language additions should have been in the policy when it was last approved at PAC in August. She also noted the addition of Partnership's definition of "closed loop referral" that is common to many of our policies.	There were no questions. Motion to **approve as presented**: Lisa O'Connell, MHA Second: Katherine Barresi, RN Next Steps: Nov. 20 Q/UAC Jan. 8, 2025 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Mark added that the closed loop definition foreshadows how closed loop referrals will be working in future: Partnership does have an obligation to make sure that the referral is made and that the appointment is kept. He noted that the additional verbiage on referrals to county substance use disorder services is in response to a Corrective Action Plan (CAP) placed on Partnership via a recent DHCS audit.	
Policy Owner: Behavioral Health – *Presenter: Anna Campbell, UM Policy Analyst*		
MCUP3101 – Screening and Treatment for Substance Use Disorders	**Section IV. Attachments:** Policy attachments C and D were archived. Instead, the requirements for Brief Behavioral Counseling Intervention/ Referral can be found in the main MCUP3101 policy document. Due to this change, Attachment E becomes Attachment C. **Section VI.A.3.b.:** Recommended ICD 10 codes for medical specialists providing office visits for SUD treatment were updated to F11.xx or F10.xx. to avoid the requirement for Referral Authorization (RAF). **Section VI.B.3.a. and VI.C.8.a. :** Deleted the word "outpatient." **Section VI.C.3.c. :** Deleted part of this paragraph describing the Application to be a Contracted Brief Behavioral Counseling Intervention/ Referral to Treatment Provider. Attachments C and D regarding the application process are archived. **Section VI.C.5. and 5.e. and 5.e.1):** Deleted the word "Contracted" Anna noted that this policy was last before IQI in May, but that Dr. Moore has since asked for some corrections. Some codes have been changed to give providers more flexibility regarding the use of RAFs.	There were no questions. Motion to **approve as presented**: Margarita Garcia-Hernandez, PhD Second: Leigha Andrews, MBA Next Steps: Nov. 20 Q/UAC Jan. 8, 2025 PAC
Policy Owner: Utilization Management – *Presenter: Colleen Townsend, MD, Regional Medical Director (Southeast)*		
MCUP3131– Genetic Screening & Diagnostics	Minor changes in the main policy: **VII. A.** Updated CDC hyperlink in References **IX:** Updated "Position Responsible for Implementing Procedure" to say "Chief Health Services Director." **Attachment A Updates:** **Code 81220:** Added ICD codes E84, X38.49 and Z31.5 as criteria **Code 81221:** Changed to require No TAR per MD review and cost <$500 **Code 81222:** Changed to require No TAR per MD review and cost <$500 **Code 81232:** New coded added for DPYD gene analysis. TAR is required with criteria that Patient had severe and unexpected toxicity (such as myelosuppression, mucositis, diarrhea, neurotoxicity, cardiotoxicity) during treatment with Fluorouracil or Capecitabine chemotherapy **Code 81259:** Changed to require No TAR per MD review and cost <$500 **Codes 81272 and 81273:** Added ICD codes D47.01 and D47.02 as criteria **Code 81336:** Changed to require No TAR per MD review and cost <$500 **Code 81337:** Changed to require No TAR per MD review and cost <$500 **Code 81405:** Added SLSLC22A5 gene (for carnitine deficiency or carnitine uptake defect) as criteria: Allowable when the newborn screen is positive for low carnitine levels or when there is clinical suspicion **Code 81406:** Added DSP gene as criteria: The patient has clinical features suspicious for Arrhymogenic Right Ventricular Myopathy ICD 10 code I42. **Code 81408:** Added COL1A1, COL1A2 genes (Osteogenesis Imperfecta) as criteria with ICD code Q78	There were no questions. Motion to **approve as presented**: Doug Matthews, MD Second: Marshall Kubota, MD Next Steps: Nov. 20 Q/UAC Jan. 8, 2025 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Code 81412: New coded added for Ashkenazi Jewish-associated disorders. A TAR is required with documented criteria to include Patient is considering pregnancy or is currently pregnant and Patient reports they are of Ashkenazi Jewish descent. **Code 81420:** New statement added to say "Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity." **Codes 81457, 81458 and 81459:** New codes added for Solid Organ Neoplasm genomic sequence analysis panel. A TAR is required with various criteria stated for both somatic and germline testing. **Codes 81462:** New code added for Solid Organ Neoplasm genomic sequence analysis panel. A TAR is required with criteria to include The patient has a diagnosis of on-small cell lung cancer, and The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible, and Management is contingent on the test results. **Code 81507:** New statement was added to say "Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity." **Codes 81517:** New code added for Liver disease, analysis of 3 biomarkers. No TAR is required. No Criteria listed. **Attachment C Updates:** **Code 0014M:** Deleted effective 01/01/2024 **Code 0204U:** Deleted effective July 2024 **Code 0242U:** Criteria for this code updated to include Hormone receptor-positive, Human Epidermal Growth Factor Receptor 2 (HER2)-negative breast cancer. Criteria removed: "~~The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible~~." **Code 0276U:** Code description updated to remove these words: "~~Hematology (inherited thrombocytopenia~~)" **Code 0329U:** Criteria for this code updated with somatic testing guidelines. **Code 0331U:** Deleted. **Code 0334U:** Criteria for this code updated with somatic testing guidelines. **Code 0337U:** Deleted **Code 0338U:** Deleted **Code 0342U:** Deleted **Code 0343U:** Deleted **Code 0344U:** Deleted **Code 0353U:** Deleted **Code 0354U:** Deleted **Code 0379U:** Criteria updated with somatic testing guidelines. **Code 0391U:** Criteria updated with somatic testing guidelines. **Code 0397U:** Deleted **Code 0408U:** New code added for Oncology (solid tumor), DNA (80 genes) and RNA (36 genes), by next-generation sequencing from plasma, including single nucleotide variants, insertions/deletions, copy number alterations, microsatellite instability, and fusions, report showing identified mutations with clinical actionability. A TAR is required. **Code 0409U:** New code added for Oncology (solid tumor), DNA (80 genes) and RNA (36 genes), by next-generation sequencing from plasma, including single nucleotide variants, insertions/deletions, copy number alterations, microsatellite instability, and fusions, report showing identified mutations with clinical actionability. A TAR is required.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Code 0448U: New code added for Oncology (lung and colon cancer), DNA, qualitative, next-generation sequencing detection of single-nucleotide variants and deletions in EGFR and KRAS genes, formalin-fixed paraffin-embedded (FFPE) solid tumor samples, reported as presence or absence of targeted mutation(s), with recommended therapeutic options. A TAR is required. **Code 0471U:** New code added for Oncology (colorectal cancer), qualitative real-time PCR of 35 variants of KRAS and NRAS genes (exons 2, 3, 4), formalin-fixed paraffin-embedded (FFPE), predictive, identification of detected mutations. A TAR is required. **Code 0473U:** New code added for Oncology (solid tumor), next-generation sequencing (NGS) of DNA from formalin-fixed paraffin-embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-mutation burden. A TAR is required. **Code 0475U:** New code added for Hereditary prostate cancer-related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for prostate cancer. A TAR is required. **Code 0488U:** New code added for Obstetrics (fetal antigen noninvasive prenatal test), cell-free dna sequence analysis for detection of fetal presence or absence of 1 or more of the rh, c, c, d, e, duffy (fya) or kell (k) antigen in alloimmunized pregnancies, reported as selected antigen(s) detected or not detected. A TAR is required. **Code 0494U:** New code added for Red blood cell antigen (fetal rhd gene analysis), next-generation sequencing of circulating cell-free dna (cfdna) of blood in pregnant individuals known to be rhd negative, reported as positive or negative. A TAR is required. Dr. Townsend noted that the policy itself is not changing much this year insofar how the review and approval of genetic testing requests occur. Most updates were in the removal of those codes not requiring a Treatment Authorization Request (TAR). More codes were added. Doctors Townsend and Moore regularly review all codes.	
V. Presentations		
1. Quality and Performance Improvement Update *James Devan, Manager of Performance Improvement*	• Measurement Year (MY) 2025 proposed Primary Care Provider Quality Incentive Program (PCP QIP) measure set was approved at October PAC. • Quality Measure Score Improvement work continues. A new internal committee has formed to develop an organization-wide strategy to address lagging measure performance under pediatric well-care visits. • The QI Locum Pilot Initiative developed earlier this year as a short term-solution to provide access to clinicians with the goal of improving Health Care Effectiveness Data Information Set (HEDIS®) performance, specifically well-child visits and cervical cancer screenings, was well received by many. Community Medical Center completed the initial grant activities and has been awarded an extension: their locum will be funded through the end of 2024 to continue focusing on well-child visits, including up to 120 Direct Members. • The Mobile Mammography Program continues to be highly effective: 518 mammograms have been completed plan-wide through Oct. 11. Eleven more event dates are scheduled this calendar year.	*For information only.* Dr. Netherda commented that the physician locum pilot has been exciting as access to care is critical. Marhsall Kubota, MD, commented that locums serving with Partnership for six months would need to be accredited by Partnership. This timeframe, however, is likely to change soon to a 60-day window, he added.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
2. 2023 PCP QIP Program Evaluation *Athena Beltran-Nampraseut, CPhT, Program Manager*	This Quality Incentive Program (QIP) runs on a calendar year. Measurement Year (MY) 2023 clinical measures were nearly identical to those for MY 2022, although two counseling measures for children were dropped and retinal eye exams were added to comprehensive diabetes care. Providers earned partial or full points across 11 measures in one of three clinical domains: chronic disease management, preventive screening or pediatric access (depending on provider type) and on five non-clinical measures across appropriate use of resources, access and operations, and patient experience. Targets for 10 clinical measures were set against HEDIS® Quality Compass benchmarks but for the colorectal cancer screening measure for which Partnership had to devise our own targets. Furthermore, providers could opt in to earn incentives on Unit of Service (UOS) measures, which were based on claims data and incentivized differently. An equity adjustment was added to the payment methodology. The gateway was that providers must have at least 100 assigned members. Core adjustments could be made on the acuity of the patient panel; socio-demographic risk rolled up to the PCP site level; site difficulty in recruiting PCP physicians, and lower than average baseline per visit resources available to the PCP. Further, "disaster" and "pediatric access" adjustments could be added if applicable to the per member per month (PMPM) rate. In a 2021-2023 year-over year (YoY) plan-wide look at the 11 clinical measures, seven saw an increase in relative change in 2023 above 2022: Immunizations for adolescents (+7.15%), diabetes HbA1c good control (+5.99%), and breast cancer screening (+4.06%) were the highest. Both MY 2023 provider "partial point" and "full points" earnings outperformed MY 2022 in both pediatric access measures (i.e., well-child visits first 15 months, and child and adolescent WCV); three preventative screenings measures (i.e., cervical cancer screening, breast cancer screening, and immunizations for adolescents), and one chronic disease management measure (i.e., diabetes – HbA1 good control). Athena went through the Relative Improvement (RI) methodology. Plan-wide MY 2023 saw a relative decline in the non-clinical domain (i.e., avoidable ED visits and risk-adjusted readmissions), yet 69% of participants earned full points in risk adjustment readmissions; 72% of participants earned full points in PCP office visits. UOS participation has been low YoY, with less than 30% of providers choosing to participate. Just 20% participated in the dental fluoride varnish UOS. YoY advance care planning has enjoyed both the highest participation and, in MY 2023, the highest payout. MY 2023 incentive payouts totaled $38.5M; the weighted average earned PMPM was $7.08. Overall by county, Del Norte, Humboldt, Lake, Lassen, Mendocino, Napa, Shasta, and Trinity providers earned more in MY 2023 than they did the prior year. In summary, MY 2023 QIP performance improved above prior year in seven of the 11 clinical measures. Four measures ended above the 50th HEDIS® benchmark; two ended about the 75th percentile benchmark. Dr. Kubota asked, and Athena confirmed, that dental fluoride has now moved to a monitoring measure in MY 2024. Dr. Netherda then thanked Athena and her manager, Amy McCune, for their hard work. Anna Campbell asked if the removal of alcohol screening from the measure list would have any impact on our policies. Dr. Netherda replied that providers are expected to do this screening as a matter of course: our site review team looks for this standard of care to be met.	2025 Program Recommendations: • Expand BCS age range from 50-75 years-old to 40-75 yo • Add new clinical measures: chlamydia screening, WCV in the first 15-30 months, and topical fluoride in children. Reduce inequity adjustment, and add academic detailing to the UOS list • Replace non-clinical risk adjusted readmissions with follow-up within 7 days after hospital discharge measure • Update the peer-led and pediatric group visit UOS measure • Raise thresholds back to 75th percentile for partial points and 90th percentile for full points

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
3. Grand Analysis: Member Experiences MY 2023 / RY 2024 *Anthony Sackett, Program Manager II, QI* and *Kory Watkins, MBA-HM, Director of Grievance and Appeals*	Anthony spoke on the MY 2023/RY 2024 regulated Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores and the unregulated survey results too and Kory of the 2023 grievances and appeals and second-level grievances before they addressed key learnings and answered questions. Nearly 1,200 Members responding to the regulated Adult CAHPS survey gave their highest marks to "rating of personal doctor," coming in at the 64th % HEDIS® benchmark, or +3.1 % higher than in last year's survey. Overall, the adult survey confirmed our 3.5 Star rating as published by the National Committee of Quality Assurance (NCQA) in September. Key findings of the non-regulated Adult survey showed that 47% of Members had no better than a fair or poor understanding of their benefits and available services. About 35.7% of these Members said they asked their providers or provider's staff for help in understanding their benefits; another 29.1% would call Partnership. More insights are reported in this report's Appendix C. Despite improved "rating of personal doctor" in both the regulated Adult and regulated Child surveys, "rating of health care" had negative rate changes from 2022 of -9.4% and -5.3%, respectively, each scoring lower than the average plan score. Kory noted that the number of grievances filed grew 28.5% (from 2,556 to 3,572) while membership across the 14 counties grew 6.3%. Of the five NCQA grievance categories – access, attitude/service, billing/financial, quality of care, and quality of provider office – only billing/financial and quality of provider office met the threshold of less than a 10% change from MY 2022. The driver behind increased negative numbers on access and attitude is largely attributable to transportation benefit issues. Rising dissatisfaction with quality of care was driven by disagreements with treatment plans. Regarding appeals and second-level grievances, the rate per 1,000 members decreased from 1.19 in 2022 to 1.02 in 2023; only quality of care failed to meet the threshold: each of these nine cases had to do with disagreement with treatment plans. More details will be available in the PULSE report to be submitted to both IQI and Q/UAC in March 2025. Anthony went over coming organizational goals (see sidebar) before opening to comments and questions. Dr. Kubota was quick to note that Partnership's Transportation staff has done a "fabulous" job given the volume of calls; unfortunately, dissatisfaction here can perhaps unfairly drive the rating of the health plan. Anthony agreed but said the situation could improve as we begin to track dissatisfaction with "bad drivers." Anna expressed surprise that of the adults saying they had only fair or poor understanding of their member benefits, only 7.9% said they have looked at the Member Handbook. Do they not find answers there? Anthony noted that Member Services does mail out member packets that include the Member Handbook and they are actively looking at other ways to reach Members. Doctors Netherda and Kubota noted that Member concerns about pharmacy benefits till get pinned on Partnership rather than the State's Medi-Cal Rx carveout vendor. Anthony added that Partnership also has no control over Denti-Cal but we get dinged on that as well.	2024/2025 Organizational Goal #4: Access & Member Experience: • Understand the landscape of our specialty provider network, identify gaps, and develop targeted action plans • Understand the landscape of our primary care provider network, identify gaps, and develop targeted action plans • Expand the "Your Partner in Health" branding campaign and implement an action plan to improve/increase member awareness
4. Grand Analysis:	Renee prefaced her remarks by stating that "availability" speaks to cultural and language considerations; "accessibility" to geographic issues. Together, these elements assess our network adequacy for both primary and specialty care.	For details, please see the narrative backing up the

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Network Access *Renee Trosky, Manager of PR Compliance, Network Services*	Network adequacy data elements include member grievances (ME7 NCQA "access" category), CAHPS survey (ME7), the Population Needs Assessment (PNA), out-of-network requests (UM), practitioner availability cultural and linguistic needs (Net 1 A), practitioner availability ratio and geographic distribution (Net 1 B, C), and accessibility of services (Net 2 A, C). In 2023, our members submitted 3,572 grievances, 43% of which may be attributed to access. This is similar to 2022, during which 41% of the 2,556 grievances submitted involved access. In 2023, appeals and second-level grievance totals decreased by 10% from 2022 but 50.1% of these were access concerns, compared to 43% in 2022. A comparison of 2022 and 2023 CAHPS Adult survey composite scores show that "getting needed care" improved slightly while "getting care quickly" declined slightly in 2023. In both years, Partnership failed to meet its benchmarks on both. Similarly, the Child Survey failed to meet 2023 benchmarks. As a Plan, Partnership met its CY 2023 goal of less than 20 out-of-network (OON) per 1,000 members. OON referrals in the more rural Northern Region was 3.8 per 1,000 Members; in the South, OON referrals was 1.8 per 1,000 Members. Modoc, Siskiyou and Del Morte counties logged the highest OON requests per 1,000 Members; while Napa, Mendocino, Yolo, and Humboldt ranked highest in Members utilizing their approved OON referrals. Renee noted that, in general, about one-half of all referrals are not used by Members. In 2023, Partnership met its primary care ratio goals in each of the four categories: primary care practitioner, family or general practice practitioner to Member, pediatrician to children, and internists to adults. Likewise, 2023 Third Next Available (3NA) primary care routine appointment accessibility goals were also met for primary care of adults, primary care for children, newborn appointments and primary urgent care. Between May 1, 2023 and Dec. 1, 2023, Partnership recruited to the network 66 new primary care practitioners, 27 of whom went to six of our most rural northern counties. Partnership continues to support workforce development strategies to recruit and retain physicians, nurse practitioners, physician assistants and licensed behavioral health counselors, including substance use disorders counselors. CY 2024 workforce development also included strengthening recruitment of support specialty providers by adding obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery. The 2024 Grand Analysis work is now underway and could be presented to committee as early as September 2025, scheduling permitting, Renee concluded.	presentation in today's meeting packet. Doctors Netherda and Kubota agreed that provider re-education work needs to occur regarding OON, particularly in the 10 expansion counties: not every patient should be referred to Stanford. Moreover, providers should not jump over closer-to-home specialty providers and go straight to tertiary care referrals, Dr. Kubota added. Anna Campbell was curious about North and South differences in utilizing referrals, and Dr. Netherda agreed it would be interesting to ask Members who did not utilize their referral appointments why they did not.

VI. Adjournment

Dr. Netherda adjourned the meeting at 3:25 p.m. IQI will next meet Tuesday, Jan. 7, 2025.

Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement

Approval Signature: *Date:*

Mark Netherda, MD
Medical Director for Quality, Vice Chair

Over/Under Utilization Workgroup

Meeting Name: Over/Under Utilization Workgroup

Objective of Meeting: Identify potential concerns for over/under utilization within the PHC network

Date: October 30th, 2024

Time: 3:00pm – 4:00pm

Location: Board Room

Owner : Dr. Moore/Dr. Ribordy

Coordinator: Radha Chebolu (Health Analytics)

Attendees:

Partnership Health Plan	Partnership Health Plan	Partnership Health Plan
☐ Robert Moore	☐ Ledra Guillory	☒ Doreen Crume
☒ Jeff Ribordy	☒ Melissa Perez	☐ Sharon Hoffman-Spector
☐ James Cotter	☐ Wendi West	☒ Lisa Malvo
☐ Mary Kerlin	☒ Stan Leung	☒ Melanie Lam
☒ Margarita Garcia-Hernandez	☐ Nancy Steffen	☐ Cody West
☒ Dejene Bikila	☒ Brian Spiker	☐ Angela Guevarra
☒ Liat Vaisenberg	☒ Shivani Sivasankar	☐ Renee Trosky
☐ Kristine Gual	☒ Radha Chebolu	☐ Lisa O'Connell
☒ Amber Newell	☐ Tiphanie Salehi	☒ Jen Kung
☒ Athena Beltran-Nampraseut	☐ Kim Palfini	☒ James Devan
☒ Garnet Booth	☐ Mark Aguirre	☒ Isaac Brown
☐ Kim Fillette	☒ Shell Swift	☐ Amy McCune
☒ Lindsey Bushey	☐ Stephanie Nakatani Phipps	☐ Katherine Barresi
☐ Sarah Browning	☐ David Lopez	☒ Deanna Watson
☒ Emily Stoller	☒ Candis Broadhead	☐ Kristina Coester
☒ Monika Brunkal	☒ Alex Brito	☐ Rebecca Garcia
☒ Penny Thomas	☐ Ruth Hood	☐ David Lavine
☐ Christopher Triolo	☐ Derick Stacy	☒ Elijah Allen
☐ Jeffrey DeVido	☐ Mark Bontrager	☒ Erin Hall
☒ Anthony Sackett	☐ Greg Allen Friedman	☐ Dominic Salido
☐ Tim Sharp	☐ Akshay Sharma	☒ Mohamed Jalloh
☒ Rasitha Rathnayake	☐ Dave Hosford	☐ Tim Sharp
☒ DeLorean Ruffin	☐ Danielle Ogren	☒ Florentina Torres
☒ Vander Harris	☒ Hanh Hoang	☒ Qi Yao
☐ Michelle Rodriguez	☐ Amber Acosta	☒ Amanda Federico
☒ Cheng Saechao	☒ Tasha Krongard	

Action Items	Presenter	Due	Revise / Approve Date
Approve Minutes from 08/06/2024		10/30/2024	

Topic	Notes
1) Introductions & Objective of Meeting *Speaker:* Dr. Jeff Ribordy	Identify potential concerns for over/under utilization within the PHC network
2) Review & approve minutes from last meeting *Speaker:* Dr. Jeff Ribordy	

Underutilization Analysis Discussion Topics	
1) PCP Visit Report Owner: HA	Discuss Findings The Overview dashboard displays the PCP visit rate across PHC's 24 counties. The Eastern region, that includes 9 out of the 10 expansion counties, is shown in green. The Eastern Region Rates, based on the first 6 months of 2024, are trending slightly lower than the Southern and Northern Regions but right above the target of 2.2 visits per member per year. Colusa county has the highest visit rates, followed by Sutter and Butte. Placer has the lowest rate, followed by Nevada and Sierra. Colusa county has the highest visit rates, followed by Sutter and Butte. Placer has the lowest rate, followed by Nevada and Sierra. The sharp drop in Yolo in Q2 of 2024 is related to the Woodland contract termination. The low rates in Solano are driven by low rates in Solano County Health Services.
2) Developmental Screening Report Owner: HA	Discuss Findings For children from the ages of 0-3 between January 2022 and June 2024, the developmental screening rate was 282 per 1,000 members. The screening rate increased from 270.4 in 2023 to 332.3 in 2024. Placer (808.7), Glenn (529.7), and Marin (486.2) counties had the highest rates. Lassen (117), Trinity (59) and Plumas (7) counties had the lowest rates. The screening rate in Napa County has been dropping since October 2023. The screening rate in Lake County dropped significantly in June 2023. There are no screenings showing in Lake County Tribal Health Center and Kaiser Vallejo in 2024. The service provider with the highest volume of screenings in Marin County was Marin Community Clinic San Rafael (1,457). In Placer County it was Roseville Pediatric Medical Group (640), and in Glenn County it was Willows Pediatrics (222). The non-White screening rate was 296.5 and the non-English screening rate was 354.9. The screening rates for male and females were very similar (~280). For ethnicity, Other (854.6), Asian (351.7) and Asian/Pacific Islander (330.5) and had the highest rates. Unknown (234.1), White (219.7) and American Indian or Alaskan Native (167) had the lowest rates. For the Language, Portuguese (547.5), Vietnamese (544) and Russian (485.1) had the highest rates. Other non-English (406.1), Spanish (345.8), and English (262.8) had the lowest rates.
3) Specialty Office Visits Owner: HA	Discuss Findings There has been an upward trend in specialty visit rates across the three regions from 2023 to 2024, with the

	Northern Region exhibiting the highest visit rate. Napa county saw the highest visit rate in 2024, followed by Butte and Lake counties and the 3 counties that had the lowest visit rates are Placer, Modoc, and Plumas. Orthopedic Surgery has the highest visit rate across all specialties, despite experiencing a downward trend in visit rates through 2024. The Northern region's rates exceeded the Southern region's rates for the same specialty. As of 2024 Q3, the overall visit rate underperformed the well managed benchmark by 44.5%. Regionally, the North and South's visit rates also underperformed the benchmark by 59% and 35% respectively. In 2024, among the specialties, Ophthalmology, Pulmonary Disease, and Nephrology outperformed the well managed benchmark, while Otolaryngology, Dermatology, and Allergy/Immunology have the lowest ratio to the benchmark. In 2024, Ophthalmology, Nephrology, and General Surgery outperformed the benchmark, and Ophthalmology, Oncology/Hematology, Pulmonary disease, and cardiovascular disease specialties outperformed the benchmark in the Southern region. Napa, followed by Solano and Lake counties had higher monthly utilization in 2024 and Lassen, Yolo, and Modoc had the lowest visit rates.
4) Post-ED Visit for Mental Illness Follow-Up *Speaker:* QI	Discuss Findings Measure Definition: The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: (1) The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). (2) The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). For measurement year 2023 (MY2023), Partnership HealthPlan of California's (Partnership's) performance on the HEDIS Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure relative to NCQA national Medicaid benchmarks is performing below the 25th percentile in all four sub regions. DHCS has set the minimum performance level (MPL) for all measures as the 50th national percentile. The following organizations have had the largest impact on the regional performance for LSC. - Health Information Exchange (HIE) with County Departments of Behavioral Health (DBH) - Integrated Community Health Workers (CHWs) in Emergency Departments (ED)

	- Integrated Community Health Workers (CHWs) in Emergency Departments (ED) - BH Nonclinical Performance Improvement Project (PIP) - IHI/DHCS Behavioral Health Demonstration Collaborative
Overutilization Analysis Discussion Topics	
1) ED CAT Scan *Speaker:* HA	Discuss Findings In 2023, Medical Center Sky Lakes, QVMA Med Ctr Providence and Memorial Hosp Providence SR had a higher percentage of ER visits for CT scans. St Helena Adventist Health, Trinity Hospital, and Kaiser Vacaville had the lowest utilization.
Future Agenda Items	PCP visit rates will continue to be monitored
Next Meeting Date: TBD	

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

MEETING AGENDA / MINUTES

Meeting/Project Name:	**Quarterly SUIQI Committee Meeting**		
Date of Meeting:	**Thurs. 11.7.24**	**Time:**	**10:00am PST**
Meeting Facilitator:	**Stephanie Wilson**	**Location:**	**Webex**

Meeting Objective/s
A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services* oversight. Activities and progress are reported to the IQIC.

Meeting Agenda		
Topic	**Person(s) Responsible**	**Time Allotted**
Welcome & Introductions	Stephanie Wilson	5 minutes
Review & Approve Minutes	Stephanie Wilson	5 minutes
BH Senior Director Update	Mark Bontrager	10 minutes
Wellness & Recovery Program Updates	Nicole Escobar / Stephanie Wilson	20 minutes
Monitoring & Oversight	Multiple	45 minutes
Walk On Items	Stephanie Wilson	5 minutes
Wrap Up & Closing	Stephanie Wilson	5 minutes

Attendees (26 total)		
Name	**Department/Division**	**Attended**
Stephanie Wilson	PHC	X
Nicole Escobar	PHC	X
Alicia Kay	PHC	X
Becky Miller	PHC	X
Deanna Bay	Humboldt County	X
Develyn Sippel	Siskiyou County	X
Dolores Navarro Turner	Modoc County	X
Dolores Plascencia	PHC	X
Doreen Crume	PHC	X
Jill Ales	Mendocino County	X
Judeth Greco-Gregory	Solano County	X
Latrice Innes	PHC	X
Leslie Evans	PHC	X

Mark Bontrager	PHC	X
Matt Ramsey	PHC	X
Michelle Thomas	Humboldt County	X
Nancy Starck	Humboldt County	X
Navin Bhandari	Mendocino County	X
Rachel Ibarra	Shasta County	X
Ryan Ciulla	PHC	X
Shawn Porter	PHC	X
Toby Reusze	Siskiyou County	X
Vivian Agudelo	PHC	X
Jen Cockerham	PHC	X

Notes, Decisions, Issues

1) Quick Welcome and Introductions
2) Review & Approve Minutes
    a. Approved by Toby Reusze / Siskiyou. Seconded by Jill Ales / Mendocino.
3) Behavioral Health Senior Director Update – **Mark Bontrager**
    a. New round of BCHIP – 5 rounds in total
    b. Mendocino County received funding for psych facility
    c. New funding under prop 1 – applications due in December. Aware of at least six in region that are applying. Many building mental health rehab. Aware of one potential project in Sacramento that is building SUD treatment beds for youth. Willing to have conversations with any county partners to discuss possibilities.
    d. BH Connect – New waiver state is seeking with federal government. Pulling federal dollars for mental health placements in institutions with more than 16 beds. County has to provide robust community services. Can cover up to six months of room and board. Encouraging because more tools in toolbox to find members housing.
4) Wellness & Recovery Program Updates, Enhancements, and Highlights – **Nicole Escobar**
    a. Beneficiary handbook.
        i. All handbooks are integrated BH tools. Partnership can contribute to county's handbook. Sending out before end of week. Includes ODS portion. Handbooks need website location where counties are storing externally. PHC will link to each county's handbook.
    b. Contingency Management
        i. Opportunity for further involvement with counties. Will be scheduling round-table. Please attend to full view discussion to determine whether it's a pathway forward.
    c. HEDIS
        i. Concern in how counties are reporting HEDIS data. Asking any questions for counties to share what expectations are being provided for HEDIS.
    d. PIP – Clinical and Non-Clinical

i. PHC responsible. Eligible for timely access. Measures exceed 80%. Option to have peer support. Few providers offer/billing peer support. Welcome to improve upon. Will focus on FUA with all 24 counties. Please reach out if any questions on PIP.

e. PHC Exec
   i. Bringing access line activities in-house. Carelon phasing out. PHC will assume Carelon's phone number for continuity. PHC improving. Be thoughtful of external dates. Goal is 7/1/25. Please be careful on sharing date as it's not concrete. New systems may change date. Will keep counties updated on progress.

f. Audits
   i. Celebrate win. Exemplary audit season. Only 1 fighting. Those identified is oversight of state. Share win with teams: counties and PHC included

5) Monitoring & Oversight
   a. Providers – **Stephanie Wilson**
      i. Onboarding new providers
      ii. Newly credentialed providers. Will send to counties once received.
      iii. Open admission. PHC monitors CalOMS. Clients entering services for SUD treatments. PHC pulls open admission reports from state and share with providers. Table shows compliance rate. PHC showed low rate in May due to system issue. PHC remedying. Compliance rate now at 95%.
      iv. DATAR – Reporting to monitor treatment capacity. PHC works with state, counties and providers to ensure data is reported. DATAR is mostly compliant. PHC provides reminders and reports info by 5th of the month. Allows time to assist providers in reporting. Due to state on 10th. Compliance rate is at 100% due to the change.
         1. QUESTION
            a. **Deanna w/ Humboldt** - How do we get data on what providers are at capacity and what aren't? Is there an easy way to access?
            b. **Stephanie w/ PHC** – DATAR is challenging. Reporting is once a month, not daily.
            c. **Nicole w/ PHC** – Making it into access line. Wants to develop a capacity tool for providers to report, but not available today. Cannot lean into DATAR due to it being monthly reporting. Part of plan going forward for a daily count.

   b. Utilization Management – **Stephanie Wilson**
      i. Residential Auth - Chart showed. Average length of stays is 46 days. Longer is due to co-occurring mental health conditions. Two denied for non-residential services.

   c. Claims Processing – **Stephanie Wilson**
      i. Dashboard shows breakdown of services by county. 1,447,819 visits. 11,630 participating members. Shows breakdown from each county of services used within each counties.
      ii. Timely access dashboard tur Oct. 1st of calendar year. Walk-in episodes increasing. Average level of days 2.6 for non-urgent. 1.7 days for urgent. Doing well with timely access.
      iii. Transitions of care – 1/1/24 thru 10/1/24 – Shows member transitions. 886 members stepped down. 495 stepping up. 254 no change (provider to provider / same level of care)
      iv. Breakdown of claims processing provided. Difference of claim lines. Claim lines is number of times a member is seen. Sees how many times counties are reaching members. Denial rate is 6%.

   d. Quality Improvement Program Activities – **Alicia Kay**
      i. Wellness & Recovery Site Reviews

e. Grievances & Appeals – **Latrice Innes**
    i. Reports submitted by mail on 10/8/24. All 4 grievances were resolved. Trend is cases are interpersonal relationship issues.
f. Member Services – **Nicole Escobar**
    i. Beneficiary access lines – Call volume is steady for Q1. 83.56% answered within 30 seconds.
    ii. Screening data
    iii. CalOMS – Being monitored. Will provide with improved experience shortly.
g. Compliance – **Stephanie Wilson**
    i. BHIN
        1. No updates for beneficiary handbook. DHCS will begin working with Tribal. PHC has one tribal provider in Humboldt and one in Mendocino. Recruitment efforts.
        2. COMMENT
            a. **Toby / Siskiyou** – Met with clinic. Interested provider for tribal.

6) Walk On Items – **Stephanie Wilson**
    a. None
7) Wrap Up and Closing – **Stephanie Wilson**
    a. Next meeting in 2025. Will work on sending invites for 2025.

Action Items

Action	Owner	Due Date
1. Send Invites for 2025 Meetings	Stephanie w/ PHC	12/31/24
2. Meetings Minutes	Jen Cockerham w/ PHC	11/14/24

MEMBER GRIEVANCE REVIEW COMMITTEE
Meeting Minutes for November 21, 2024

The Member Grievance Review Committee (MGRC) represents a multi-disciplinary oversight forum with representatives across multiple Partnership HealthPlan departments to track and trend Grievances, Appeals, Exempt Grievances, and State Hearing cases. It serves as a collaborative work group to discuss complex cases or improvement opportunities with the following key focus areas: quality improvements, clinical oversight, operational excellence, member experience, and regulatory compliance. Findings may be presented in the Internal Quality Improvement (IQI) Meeting and/or Quality Utilization Advisory Committees (QUAC).

DATE:	*Thursday, November 21, 2024*
TIME:	*2:00 p.m. to 3:00 p.m.*
LOCATION:	***WebEx link in meeting invite**
	Fairfield West | *Board Room*
	Airpark | *Burney Falls Conference Room*
	Avtech | *Whiskeytown Conference Room*
	Mark Netherda, MD, Medical Director, Quality
FACILITATOR:	*Kory Watkins, Director, Grievance & Appeals*
	Latrice Innes, Compliance Manager, Grievance & Appeals

ATTENDEES			
☐	Aaron Maxwell, Transportation	☐	Mary Kerlin, Provider Relations
☒	Anthony Sackett, Quality	☒	Melissa Perez, Provider Relations
☐	Amanda Bernal, Population Health	☒	Michelle Mootz, Transportation
☐	Bettina Spiller, MD, Health Services	☒	Mori McLennan, Grievance & Appeals
☐	Danielle Biasotti, CPhT, Care Coordination	☐	Mohamed Jalloh, Pharm D, Health Equity
☐	Edna Villasenor, Member Services	☐	Nicole Talley, Behavioral Health
☒	Gary Robinson, Compliance	☐	Nicole Curreri, Population Heath
☒	Garnet Booth, Provider Relations	☐	Nikki Rotherham, Claims
☐	Hanh Hoang, Provider Relations	☒	Nisha Gupta, Population Health
☒	Hannah O'Leary, Population Health	☐	Ramneek Kaur, Population Heath
☐	Heather Esget, Utilization Management	☒	RayLyn McBroome, Grievance & Appeals
☐	James Cotter, MD, Health Services	☒	Rebecca Stark, Administration
☒	Jayne Cappello, Grievance & Appeals	☐	Renee Trosky, Provider Relations
☐	Katherine Barresi, RN, Care Coordination	☒	Robert Bides, RN, Quality
☒	Kenzie Hanusiak, Compliance	☐	Robert Moore, MD, Health Services
☐	Kermit Jones, MD, Medicare Services	☐	Rosemenia Santos, RN, Quality
☒	Kory Watkins, Grievance & Appeals	☒	Stan Leung, Pharm.D., Pharmacy
☒	Latrice Innes, Grievance & Appeals	☐	Stephanie Nakatani-Phipps, Provider Relations
☐	Ledra Guillory, Provider Relations	☐	Tim Sharp, Administration
☐	Lisa Ooten, Pharm. D., Pharmacy	☐	Tony Hightower, Utilization Management
☐	Lonni Hemphill, CPhT, Compliance	☒	Vicquita Velazquez, Health Equity
☒	Manleen Randhawa, Population Health	☒	Vivian Gill, RN, Grievance & Appeals
☐	Maria Cabrera, Member Services	☐	Wendi Davis, Administration
☒	Michela Englehart, Administration		
☒	Mark Netherda, MD, Health Services		

HANDOUTS			
1	Meeting Agenda	2	Meeting Minutes from May 23, 2024
3	Meeting Minutes from August 29, 2024	4	Meeting PowerPoint Presentation

I. WELCOME & INTRODUCTIONS

A. Meeting Minutes

Minutes from the MGRC meeting on May 23, 2024 were reviewed and approved without changes
Motion to Approve: Gary Robinson
Second: Michelle Mootz

Minutes from the MGRC meeting on August 29, 2024 were reviewed and approved without changes
Motion to Approve: Gary Robinson
Second: Hannah O'Leary

II. STANDING AGENDA

A. Old Business

1. Quality Assurance

- Several Grievance Case Analyst used the incorrect reporting categories, outcomes and case types in their cases. The staff was provided additional training during the All Staff meeting on September 11, 2024. This issue is now closed.

B. Department Updates

1. Department Updates

DHCS

- DHCS CAP response was accepted 10/30/24. To recap, DHCS did not like G&A's Second Level Grievance process. By giving the member the right to file a Second Level Grievance (SLG) it gives G&A a full 60 days to review a member's complaint when everything should be completed within 30 days. We worked with RAC reviewing the APL and everything DHCS said we needed. We came up with a new process that satisfies NCQA and DHCS, when there is an adverse benefit decision on a grievance, G&A will give the member the right to file an appeal. Training the G&A team of the new process will be happening in the next couple of weeks and the rollout will be January 1, 2025.
- We submitted all of the pre-audit documents DHCS requested for the upcoming audit December 9-20, 2024
- DHCS requested 72 case files (Quality of Care, Quality of Service/Transportation, and Appeals) for the audit

  Q: With removing the SLG will there be another identifier in its place so other departments will know?

  A: Yes, it will say in the remarks that we have given the member the right to appeal the decision. Currently in the remark where it says SLG "yes" it will say appeal rights "yes".

NCQA

- Submitted the updated documents removing SLG for the consultant to review. We wanted to ensure they are aware of the update with the new process to ensure it aligned with NCQA requirements.
- Quarterly file review of Appeals was submitted timely.

D-SNP

- Currently working on the Medicare Project Plan and Internal Risk Assessment. There were deliverables requested that were submitted timely.
- G&A leadership continues to review D-SNP requirements to assess impacts on current processes

JIVA

- G&A has been participating in DGA sessions with ZeOmega and Clearlink. Sessions for grievances, appeals, and PQIs are still taking place. We are expecting a copy of our Jiva workflows from ZeOmega soon.

Process Improvements

- Updating our process for discrimination cases to include a letter to providers to advise them when we find that discrimination likely did NOT occur following allegations from a member. Currently we only notify the provider if discrimination was likely. We developed a new letter calling it "Discrimination Unlikely Letter" this letter will notify the provider that we found the discrimination the member alleged did not likely occur after investigation. We are working with Dr. Townsend, who will be signing the letter. We will also be reaching out to Dr. Jalloh to inquire about having his name or contact information on the letter as well. This will be beneficial for the provider if they would like to have additional resources or have the staff re-trained. The rollout of the letter will be the beginning of 2025.

  Q: Will the letter be included in the DEI training processes?

  A: No, not at this time. We are in the beginning stages of writing the letter. We will be reaching out to Dr. Jalloh to obtain his thoughts and confirm if his contact information can be added to the letter in case the provider would like any additional training.

- Working with Transportation Services to enhance track and trending capabilities. We have implemented adding the trip number to the grievance. Allowing us to be able to report the grievance back to Transportation department with the trip number will show who the driver was. Another item we are working with the Transportation department on is when the member schedules a ride and is contacted confirming the ride and whom the ride will be with, often times the member will cancel the ride. When the ride is cancelled we would send a NOA saying we denied the ride, when in hindsight we did not deny the ride, we scheduled the ride which the member declined. The NOA will no longer be being sent out for this reason.

Q: Is there a DNT (Do Not Transport) list?

A: Transportation will be focusing on educating first, but there are black lists in the works, just not implemented yet.

2. Staffing

We had one (1) vacant GCA positions open; we made an offer to a candidate and they have accepted with a start date of December 9, 2024. Once they start, the G&A department will be fully staffed.

The G&A department structure is split into two sides. Latrice is the Compliance and Strategy Manager. Latrice oversees the auditing, training and the reporting. On the other side, Mori is the Operational Manager. Mori has two (2) supervisors, who see the day-to-day operations, five (5) nurses and two (2) State Hearing Representatives who also report to her.

B. Case Statistics

1. Case Statistics

There were 2,008 cases closed in 3Q24. Forty-five (45) cases were closed past 30-days, resulting in a 97.4% timeliness performance rate for the 3Q24. Members were notified their case was received within five (5) calendar days of receipt for all but 30 cases resulting in a 98.3% timeliness rate. G&A's timeliness goal is 98.6%, which was not met for the third quarter; however, the numbers have been improving since the second quarter.

G&A has been working on becoming fully staffed and working hard. In October, we were able to meet the timeliness goal and we are on track to doing the same for November.

There was one (1) lost State Hearing in July for the 3Q24 regarding facial masculinization surgery that was discussed at the July MGRC meeting. There have been a few more overturned State Hearings since July. One in particular stands out which was related to transgender surgery. We did not agree with the decision so we appealed the ALJ's decision. We currently are still waiting for the next steps. The last time G&A appealed a State Hearing decision was 10 years ago. We obtained approval from Dr. Moore to appeal the decision and have received confirmation the appeal was received and being called a Re-Hearing. However we still have to approve the services in our system so the member could possible receive the treatment even though we have filed the appeal.

G&A has closed 767 cases in October. That is the highest amount of cases that G&A has closed in a month. Those cases consisted of 580 Grievances, 79 Appeals, 67 Exempt cases and 41 State Hearings.

In the last MGRC meeting, we discussed the trends of Appeals Received so now we are discussing the trends of Cases Received comparing 2023 to 2024. The trends show that during the winter months, we typically receive fewer cases compared to the summer months. However, in October, there was an increase in cases received. We are watching the trends specifically to see if when we make changes with another department; we want to see how it will affect the trends.

C. Compliance & Strategy

1. Delegation Oversight

Carelon
Carelon's annual review score was 100%. Carelon will be de-delegated from grievance case processing effective July 1, 2025. At the beginning of the year, we requested the unresolved cases reported for the previous quarter. This report has been challenging to obtain from Carelon quarterly.

Q: Since Carelon will be de-delegated on July 1, 2025, will we not need the supplemental report of those cases closed the previous quarter anymore?
A: Correct, we will not need those reports.

Q: If Carelon grievances will be brought in-house, how will that affect the PQI referrals? Will G&A be investigating quality of care issues?
A: As of right now, all of the specifics are still being discussed in de-delegation meetings. Latrice will bring this question forward at the next meeting.

Kaiser Permanente
Kaiser submitted the 3Q24 quarterly report timely.

VSP
VSP submitted 3Q24 quarterly report timely.

2. Inter-Rater Reliability (IRR) Findings
IRR assesses the accuracy of clinical decisions made by GNS. The assessment is completed by the Chief Medical Officer (CMO), or his designee, and provides a clinical oversight on cases that are at higher risk for errors. The cases are also assessed by G&A leadership to identify learning opportunities. The following issues were identified during the assessment of cases closed in 2Q24:

- This case could have been sent to a Medical Director, as the case involves timed dialysis care. The late transportation provider is directly affecting the care of the member by infringing on the time the member can be dialyzed. Records from the Dialysis center could confirm if this has occurred more than once for this member.
- This will be discussed during the Bi-Weekly GNS meeting on November 26, 2024.

3. The PULSE Report
The 4Q24 PULSE Report was released November 11, 2024. If you would like to be added to the email distribution list, please email Latrice. The report can also be found on the Grievance and Appeals page on PHC4ME.
A highlight to look for:

- Statistics Broken Down by Region
- Increase in Transportation State Hearings

C. *Investigations*

Case Spotlight

Issue:
Member requested gas mileage reimbursement for two nights due to the travel distance between their provider's office and the member's home. Our transportation department approved one date, but denied the other despite having proof that the service rendered was medically necessary.

Background:
The NOA and appeal were documented with incorrect denial dates; therefore, the Medical Director upheld the denial of the April 24, 2024, date and approved the April 25, 2024, date. The State Hearing Representative reviewed the case with the Medical Director in more detail and it was determined that both April 24, 2024 (the night before the procedure), and April 25, 2024, the day of the procedure should have been approved.

Learning Opportunity:
Partnership should have authorized lodging for the member for April 25, 2024 and April 24, 2024, as lodging for both nights was medically necessary and reasonable given the long travel distances between the member's home and the provider's office. The Grievance Case Analyst should have been more thorough in their documentation and confirmed the dates of the requested gas mileage reimbursement.
Transportation department has reviewed this case and implemented tighter auditing on their side as well.

Q: Is there an opportunity for shadowing G&A and Transportation?
A: Yes, please reach out to Mori McLennan for scheduling.

FOLLOW-UP

Next Meeting: *Thursday, February 27, 2025 | 2 p.m. – 3 p.m.*

MEETING MINUTES

Meeting Name: Population Needs Assessment Committee

Date: Dec. 4, 2024 **Time**: 4 - 5 p.m.

Location: Marin Conference Room; Webex

Attendees: DeLorean Ruffin, DrPH; Garvin Lum; Hannah O'Leary; Liat Vaisenberg; Margarita Hernandez; Mohamed Jalloh, PharmD; Robert Moore, MD
Virtual Attendees: Amanda Smith; Christine Smith; Colleen Townsend, MD; Greg Allen Friedman; Jill Blake; Katherine Barresi, RN; Kathryn Power; Lilian Merino; Lisa O'Connell; Marshall Kubota, MD; Monika Brunkal, RPh; Nancy Steffen; Rebecca Stark; Tim Sharp; Wendi Davis; William Kinder; Yolanda Latham
Absent: Aaron Maxwell; Denise Rivera; Isaac Brown; Jeff Ribordy, MD; Mark Bontrager; Matt Hintereder; Priscila Ayala; Richard Matthews, MD; Vicky Klakken

Agenda Topic	Minutes	Action Items
1. Intros *Time: 5 minutes* *Speaker: Hannah*	• New CHNL starting 12/9: Wendy Starr in Eureka • Hiring for CHNL position in Auburn	

2. CHA/CHIP updates
Time: 30 minutes
Speaker: Hannah
	A PowerPoint presentation was used during this discussion, attached with these minutes.
	
	• PHM Deliverable Update (slide 3):
	  ○ The PHM Deliverable was submitted to DHCS on 11/22/2024.
	
	• MCP-LHJ Worksheet Status (slide 4), 1 refusing to sign, 4 counties still in progress:
	  ○ Shasta still refuses to sign without going through a full MOU-like process. The current point of contact is currently on leave. We will continue to work with them when they return.
	  ▪ Wendi can help connect the CHNL team with the interim/acting director in Shasta if needed.	

Agenda Topic	Minutes	Action Items
	○ The 4 counties in progress are Humboldt, Mendocino, Sutter, and Yuba. ▪ Humboldt is waiting for a response from us to their funding proposal prior to signing. Mendocino is in a holding pattern. ▪ Yuba and Sutter have had a lot of back and forth, but the conversation is happening. • Goal Status (slide 5) ○ 14 goals have been drafted, but need full county buy-in. ○ The PNA Committee previously approved a goal with Yuba, but it's no longer moving forward, so talks about new goals are ongoing. ○ Yuba and Sutter have asked us to commit to three goals per county to align with their CHIP. That should be doable, as the goals chosen can be supported by existing work at PHC. ○ Three counties currently do not have a goal (Sonoma, Marin, and Mendocino). The CHNL team is continuing discussions with them. ○ Del Norte has identified a priority area in adolescent immunizations. • Napa County Goal – Transportation (slides 6-8): ○ The county wanted to shoot for a 15% increase in utilization. However, there is concern that this goal does not state a clear target (i.e., utilization from X% to Y%). ▪ Another possible way to measure similar issues could be through no-show numbers. ▪ Ultimately, transportation is the top benefit people are not aware of – if we raise awareness, utilization should go up across all groups, not just seniors. ○ Napa city has pretty good public transit – it seems the idea is to leverage the Napa public transit authority to move members around the county. ▪ Partnership can only help as an MCP with a transportation benefit – it's likely this goal will cover more than just Partnership's members. • Aside: we've discussed paying for things like bus passes with the transportation benefit, but there's no tracking per ride with those. ▪ Two Napa organizations are interested in improving transportation for seniors, but that may not even be medical-related transportation. ○ The current goal reads like one created for Partnership – the goal should be rewritten for what county wants to achieve. Instead of "MCP transportation," they	• Rework goal language w/ KP, including a clearer target. Broader goal, with PHC being a component of the goal, or tentative goal until acquisition of data.

Agenda Topic	Minutes	Action Items

	could say "increase utilization of transportation," etc. They can make it a broader goal, with the understanding that Partnership will help with the areas in our jurisdiction (transportation for member care). The goal language should include baseline numbers with a clear target and percents (i.e., bring utilization from X% to Y%). Without that, it should be considered a tentative goal.
	
	• Napa County Goal: Well Child Visits (slide 9)
	  ○ Improved data that is in progress will significantly impact the success of this goal. It aligns with DHCS. This goal looks fine.
	
	• Solano County Goal (slide 10)
	  ○ This goal was previously approved, but new strategies have been added.
	  ○ In Strategy 2.1, the passport concept is not fully fleshed out. There's a concern that people won't remember to take a paper with them to appointments, if this is intended to be a physical passport.
	  ▪ This is in partnership with Kaiser and is intended to leverage existing resources and tried passport methods. However, there is more than Kaiser in that county, and any passport needs to account for all of a member's appointments.
	  ▪ Partnership's role within this would be education – there are existing health education materials that can be used, VaxFacts, and the Growing Together Program (GTP).
	  ▪ Before this can be approved, all the FQHCs in Solano could be in the conversation. Places like Ole Health, La Clinica, and others shouldn't be committed to Strategy 2.1 without their knowledge. We'd prefer a more flexible version of the idea, not a centralized approach (e.g., a paper the member takes with them to appointments).
	  ○ It's important for members to get their next appointments when leaving – our health materials could help if that window is missed. The recommended vaccine schedule is on the VaxFacts website for Solano.
		• Approved
		
		• Strategy 2.1 could be modified to be targeted more towards health education. If the passport is desired, Solano would have to clear the idea with all local FQHCs. We recommend a flexible approach to the passport, if it goes forward.

Agenda Topic	Minutes	Action Items

	• Trinity County Goal (slide 11)
	  ○ Some modifications were made, Carelon removed.
	  ○ The goal looks fine, but going to 39.79% is a little odd. Let's change that to 40%, and include language about a follow-up in 30 days. Otherwise, it's approved.
	
	• Yolo County Goal (slide 12)
	  ○ The state is not giving us any fluoride varnish data. The baseline is close to "0" due to that. Data is difficult in this area – Partnership's QI team estimated the real rates and they're pretty good. Dentists are doing it as part of standard dental appointments, but it's not getting reported.
	  ○ We can give them data on how many kids are having 2 dental visits a year. We have data on visits, but not fluoride varnish specifically.
	  ○ The ultimate goal is to prevent dental caries – it would be more productive to focus on kids not going to the dentist. We suggest Yolo considers the rate of children getting oral hygiene visits as better measure. The major problem is kids with 0 visits. Medi-Cal covers 2 visits per year from ages 1-20. Within that range, they could focus on kids getting 0 or 1 visit in per year, with the goal of 2 visits per year.
	
	• Humboldt Resource Request (slides 14-15)
	  ○ Revisiting the last bullet in Humboldt's resource request: funding.
	  ▪ If we do it for one, it'll be expected by all. We don't have this money available. It could go to executives but will almost certainly be denied. All the other bullets on slide 14 are doable, and replicable across all counties as needed.
	  ▪ We can tell the county that funding from us is not possible.
	  ▪ The resource request form doesn't have a space for funding, Humboldt used the "other" category and filled in the blank. We will leave the form as is.
	
	• Lake County Resource Request (slide 16)
	  ○ Lake asked for funding for a speaker.
	  ○ Not sure executives will fund this, but it should be brought to them.
	  ○ We recommend Lake focuses on the term "nicotine" over "tobacco."
		• Approved, with edits to be added.
		
		• Based on back-engineered data, the rates are pretty good for fluoride varnish. Can run a report for the county if needed. We suggest a preventative goal for kids getting less than 2 dental visits per year. Those getting 0 visits are most critical.
		
		• Funding request from Humboldt is not possible at this time.
		
		• To be brought to executives for approval.

Agenda Topic	Minutes	Action Items

3. Open Discussion
Time: 10 minutes
Speaker: All
	• Four Data Requests Received
	  ○ As a reminder, when counties have data requests, PHM's Community Health Needs Liaisons (CHNLs) will intake the request, then it will go to this committee for vetting, and depending on the decision, it will either go back to the requester (rejection) or move on to the Data Governance Committee to be run by Margarita.
	  ○ Requests that we think are beneficial may go into the next year's Annual County Data Reports.
	  ○ Dr. Moore is available to review these and future requests.
		• Dr. Moore will review the requests and recommend whether to move them forward to the Health Analytics meeting.

4. Next steps *Time: 5 minutes* *Speaker: All*	• Reminder: if attending a CHA/CHIP-relevant meeting, don't forget to send the CHA/CHIP team your notes!	

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CHA/CHIP Updates

Hannah O’Leary, MPH, CHES

December 4, 2024

DHCS Deliverables

Five Part PHM Deliverable Update

Shared Goal/SMART Objective

PHC/LHC meaningful participation

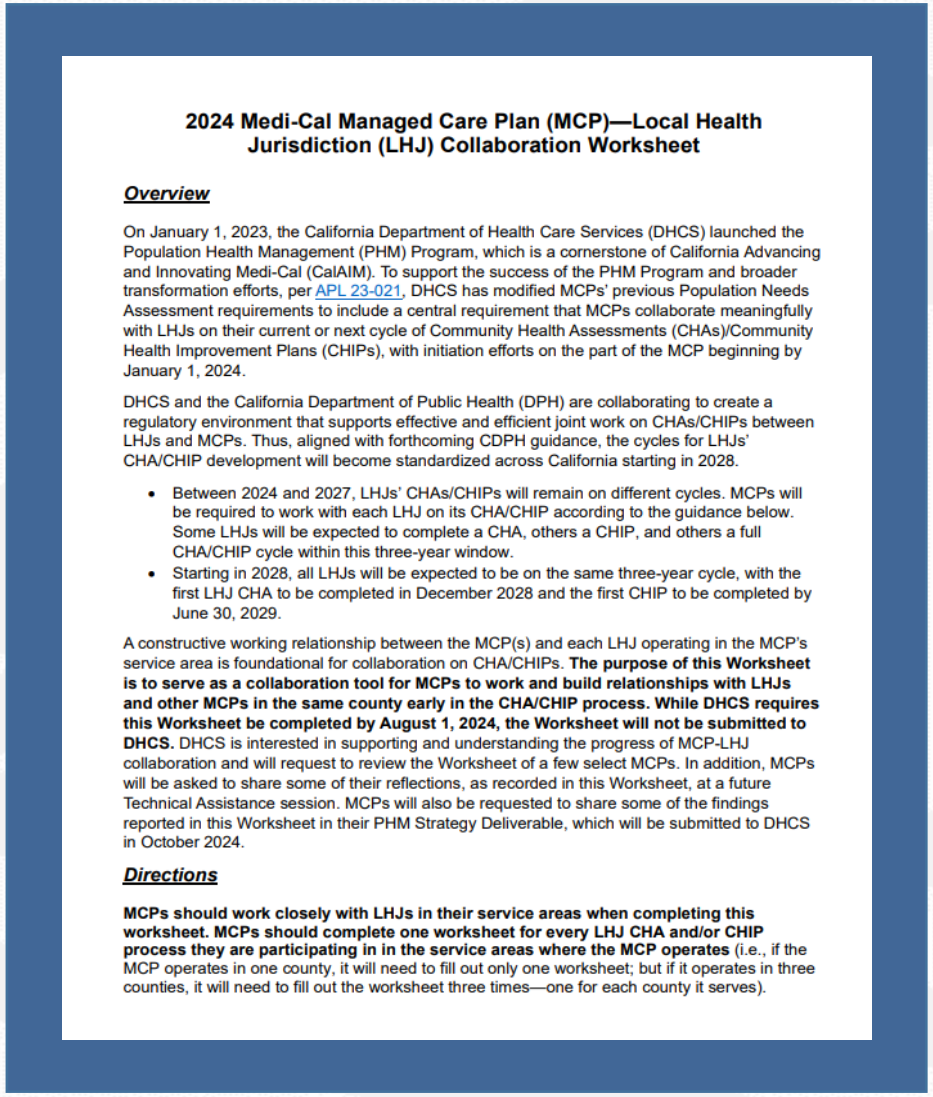
CHW Monitoring KPIs

MCP Bold goal projects

NCQA information

MCP-LHJ Worksheet Status

- 1 county refused to sign
- 4 counties are in progress



2024 Medi-Cal Managed Care Plan (MCP)—Local Health Jurisdiction (LHJ) Collaboration Worksheet

Overview

On January 1, 2023, the California Department of Health Care Services (DHCS) launched the Population Health Management (PHM) Program, which is a cornerstone of California Advancing and Innovating Medi-Cal (CalAIM). To support the success of the PHM Program and broader transformation efforts, per APL 23-021, DHCS has modified MCPs' previous Population Needs Assessment requirements to include a central requirement that MCPs collaborate meaningfully with LHJs on their current or next cycle of Community Health Assessments (CHAs)/Community Health Improvement Plans (CHIPs), with initiation efforts on the part of the MCP beginning by January 1, 2024.

DHCS and the California Department of Public Health (DPH) are collaborating to create a regulatory environment that supports effective and efficient joint work on CHAs/CHIPs between LHJs and MCPs. Thus, aligned with forthcoming CDPH guidance, the cycles for LHJs' CHA/CHIP development will become standardized across California starting in 2028.

- Between 2024 and 2027, LHJs' CHAs/CHIPs will remain on different cycles. MCPs will be required to work with each LHJ on its CHA/CHIP according to the guidance below. Some LHJs will be expected to complete a CHA, others a CHIP, and others a full CHA/CHIP cycle within this three-year window.
- Starting in 2028, all LHJs will be expected to be on the same three-year cycle, with the first LHJ CHA to be completed in December 2028 and the first CHIP to be completed by June 30, 2029.

A constructive working relationship between the MCP(s) and each LHJ operating in the MCP's service area is foundational for collaboration on CHA/CHIPs. **The purpose of this Worksheet is to serve as a collaboration tool for MCPs to work and build relationships with LHJs and other MCPs in the same county early in the CHA/CHIP process. While DHCS requires this Worksheet be completed by August 1, 2024, the Worksheet will not be submitted to DHCS.** DHCS is interested in supporting and understanding the progress of MCP-LHJ collaboration and will request to review the Worksheet of a few select MCPs. In addition, MCPs will be asked to share some of their reflections, as recorded in this Worksheet, at a future Technical Assistance session. MCPs will also be requested to share some of the findings reported in this Worksheet in their PHM Strategy Deliverable, which will be submitted to DHCS in October 2024.

Directions

MCPs should work closely with LHJs in their service areas when completing this worksheet. MCPs should complete one worksheet for every LHJ CHA and/or CHIP process they are participating in in the service areas where the MCP operates (i.e., if the MCP operates in one county, it will need to fill out only one worksheet; but if it operates in three counties, it will need to fill out the worksheet three times—one for each county it serves).

Goal Status


Four Goals are pending approval
Fourteen goals are drafted
Goal Updates
Three have no goals
One identified priority areas

Napa County Goal: Transportation – Part 1

Goal: Reduce health inequities and help ensure well-being of individuals through system analysis and innovation.

SMART Objective: By December 31, 2025, increase utilization of MCP transportation benefits by 15% above the base line rate among adults over age 60, individuals with a disability, families with children younger than 15 months, and among Black, Indigenous, People of Color (BIPOC) in Napa County.

Napa County Goal: Transportation – Part 2

Transportation Benefits

1.1 - By February 28, 2025, complete a comprehensive MCP transportation landscape analysis in Napa County including, but not limited, to transportation providers, utilization trends and population stratifications specific to Napa County residents to identify improvement opportunities.

1.1.1 – Provide transportation benefit utilization data for 2024 for Napa County residents by age categories and race/ethnicity for the purpose of informing targeted outreach efforts by January 31, 2025.

1.1.2 – Provide transportation benefit utilization data for the first half of 2025 for Napa County residents by age categories and race/ethnicity for the purpose measuring progress toward the shared SMART goal by July 31,2025.

1.1.3 - Provide transportation benefit utilization data for 2025 for Napa County residents by age categories and race/ethnicity for the purpose of measuring progress toward the shared goal by January 31,2026.

2.2 By June 2025, in collaboration with Kaiser Permanente and Partnership Health Plan, leverage the existing transportation coalition to coordinate efforts that will focus on identifying service providers across Napa County and addressing gaps in current transportation offerings.

2.2.1- By March 31, 2025, develop and begin implementation of an action plan to address identified disparities and gaps in utilization of transportation benefits in Napa County.

Napa County Goal: Transportation – Part 3

Targeted Education Campaign

3.1 – By December 31, 2025, deliver managed care plan transportation benefit and data overview to LHNC partners and to at least five other relevant healthcare coalitions to foster collaboration and support.

3.2 – By June 30, 2025 create and distribute an MCP benefit flyer to 90% of Partnership FQHC patients.

Napa County Goal: Well Child Visits

Goal: Increase the rate of Well Child Visits among children ages 0-15 months.

SMART Objective: Increase well child visit rates for children in Napa County during their first 15 months from 32.35% to meet or exceed the Medicaid 50th percentile benchmark of 58.38% by December 31, 2025.

Incentivize Well - Child Visits

1.1 Utilize Partnership Health plan's Growing Together Program (GTP) to incentivize well-child visits for the first 2 years of life through outreach, education, and gift cards that reward timely well-child visits.

2.1 improve utilization of transportation benefits through education (flyers, presentations, etc.)

Solano County Goal

Goal: Improve the percentage of children aged 0 to 30 months who receive well-child visits

SMART Objective: By December 2025, Solano County and the health plans will work collaboratively to develop targeted community and MCP-specific interventions that improve the percentage of children aged 0 to 30 months who receive well-child visits to meet or exceed the DHCS 2023 MPL benchmarks of 58.38% receiving six or more visits for ages 0 to 15 months and 66.76% receiving two or more visits for ages 15 to 30 months.

Enhance Health Education Strategies

1.1 By November 2024, survey community stakeholders to identify effective strategies for a shared or county-wide approach to disseminating health education best practices related to managed care plan benefits, member-based programs, and quality improvement initiatives.

2.1 By December 31, 2025, implement a county-wide approach to share a member-driven Early Childhood Passport that helps parents and guardians track their child's visits and immunizations. This initiative will involve community organizations and social services as key stakeholders to address barriers to access and reduce racial and ethnic disparities in early childhood preventive care.

Trinity County Goal

Goal: Increase follow up for SUD clients treated in the ED for SUD related complaints.

SMART Objective: By December 31, 2025, increase follow-up care for individuals with substance use disorders (SUD) who present to the emergency department with SUD-related healthcare needs from a baseline of 36.84% to 39.79%.

Strategy 1.1 SUD Workgroup – Develop and implement a comprehensive referral system from the emergency department (ED) to County Behavioral Health.

Strategy 2.1 Outreach Initiatives – Expand outreach efforts to increase awareness about available Behavioral Health services, SUD programs, and PHC transportation services through outreach materials to individuals and community partners.

Yolo County Goal

Goal: Improve FV rates/children's oral health outcomes

SMART Objective:
By December 31, 2025, improve FV rates/children's oral health outcomes through improved FV application rates and documentation by 5% from baseline.

Establish Billing Accuracy Baseline
1.1 By June 2025, establish a baseline measurement of the current FV billing code submission accuracy among PCPs within our network, using data from billing records and chart audits.

Fluoride Varnish Training and Provider Incentives
2.1 By December 31, 2025, deliver provider education or training within our network to enhance providers' competency in fluoride varnish application to improve children's oral health outcomes and documentation to ensure billing accuracy.

School-based Intervention
3.1 Coordinate with school administrators and healthcare providers to integrate oral health screenings and FV application sessions into existing health education programs.

Resource Requests

Humboldt Resource Request

- CHA/CHIP meetings
- Project management
- Supportive leadership
- Stakeholder engagement
- Other administrative tasks
- Other: funding

Humboldt Resource Request

Request for funding

- $41,523 - Live Well Humboldt Dashboard
- $65,000 - Live Well Humboldt Steering Committee
- $50,000 - Community Health Assessment Survey

Total ask: $156,523

Lake County Resource Request

Request for funding for:

- Renowned speaker and expert in tobacco and substance use prevention
  - Speaker with Assessment - $12,000
  - Venue Rental - $3,000
  - Promotion and Food - $3,000

Total ask: $18,000

PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI Department Update
January 2025
Prepared by Nancy Steffen
Senior Director, Quality and Performance Improvement

Quality Incentive Programs (QIPs)

PROGRAM	UPDATE
Primary Care Provider quality Incentive Program (PCP QIP)	• At the close of business on 12/31/2024, Measurement Year (MY) 2024 concluded and eReports was taken offline to apply Continuous Enrollment criteria and Relative Improvement logic to clinical measure denominators. eReports will be available to providers once again on Monday 01/13/2025, permitting uploads of medical record data to represent completed services through year end. Uploading will be permitted until 5:00pm on 01/31/2025. • Small denominator exclusion requests for MY2024 will be accepted through 01/31/2025. • All Unit of Service measure submissions for MY2024 are due by 5:00pm on 01/31/2025. • The MY2025 Abridged Specifications document was posted to the public facing website on 01/01/2025. MY2025 Detailed Specifications can be requested via email and will be accessible online via eReports, when it launches in early March. • The MY2025 Kick Off Webinar is scheduled for Wednesday, 01/15/2025 at Noon.
Dual Special Needs Plan (D-SNP) Quality Incentive program (QIP)	• The QIP team is finalizing its D-SNP PCP Incentive Program (D-SNP QIP) proposal, including the MY2026 measure set with methodologies for determining provider entry, measure targets, and scoring criteria to assure alignment with Partnership's STARs strategy and goals for its D-SNP product line. • In parallel, the QIP and IT teams are exploring vendor options for the development of a system solution for performance tracking of the D-SNP QIP, once launched in January 2026. All completed Requests for Proposal (RFP) were received in December 2024 and vendors offering solutions are currently being scheduled for demos.
Palliative Care Quality Incentive Program (Palliative Care QIP)	• MY2025 specifications are now available on the Partnership public facing webpage, under Quality, QIP.
Perinatal Quality Incentive Program (PQIP)	• No Updates
Enhanced Care Management quality Incentive program (ECM QIP)	• Q2 2024 payments have been distributed. • MY2025 specifications are now available on the Partnership public facing webpage, under Quality, QIP.

HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)	• No Updates

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• The MY2025 PCP QIP Business Requirements Document (BRD) is in development. The PQD Workgroup, representing cross-departmental contributors and stakeholders, is also finalizing the annual PQD update timeline given the impending implementation of the new core claims system, HRP, in early 2025.
EREPORTS	• MY2025 eReports is in development and presently undergoing User Acceptance Testing (UAT). • MY2025 eReports is scheduled to launch in March 2025.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE
STATE-MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	*Institute for Healthcare Improvement (IHI) / DHCS Medi-Cal Child Health Equity Collaborative* • This collaborative is focused on improving child health equity, specifically for pediatric well-care visits. • Partnership and Stallant Health and Wellness in Del Norte County are collaborating in a project. The populations of focus are Native American / Alaskan Native and Hispanic populations. Defined Aims for targeted populations are as follows: ○ Partnership in collaboration with Stallant Health & Wellness will increase the annual well-care visit completion rates for the Native American/Alaskan Native population who are 3-17 years of age from 8% to 25% by March 2025. ○ Partnership in collaboration with Stallant Health & Wellness will increase their annual well-care visit completion rates for the Hispanic population who are 3-17 years of age from 20% to 40% by March 2025. • The 3rd phase of this collaboration began on 08/22/2024 and continues per an active Plan-Do-Study-Act (PDSA) cycle. ○ Through additional discovery, it was determined that a vast majority of the patients assigned to Stallant who are Native American/Alaskan Native are seeking care at another local contracted primary care provider. Efforts are currently underway to initiate member re-assignment to accurately represent where each member is seeking care, and therefore has shifted the focus of this PDSA to only the Hispanic population.

- Stallant has launched a PDSA focusing on additional touch points prior to scheduled pediatric well-care visits. The goals are to better ensure the parent/guardian is educated on the reasons for and importance of well-care visits, as well as ensuring access to necessary pre-appointment paperwork in advance of the appointment. This includes making sure the paperwork is available in Spanish, where needed.

IHI / DHCS Medi-Cal Behavioral Health Demonstration Collaborative

- DHCS and IHI have also launched a Behavioral Health Demonstration Collaborative to continue the work already started by the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Partnership, along with the Nevada County Behavioral Health Department, were selected by DHCS to participate in this collaborative.
- The Partnership/Nevada County DBP team is working to select and launch an initial intervention.
- This collaborative will run April 2024 through June 2025. It has three (3) Action Periods where quick interventions will be implemented within Nevada County and evaluated to impact the following measures:
  - % of Medi-Cal members with 30-day follow up after Emergency Department visit for mental illness (FUM)
  - % of Medi-Cal members with 30-day follow-up after Emergency Department visit for substance abuse (FUA)

Performance Improvement Projects (PIPs) Update

As a contracted managed care plan (MCP), DHCS assigned two (2) PIPs to Partnership that will be completed over 2023–2026. Annual submissions for both PIPs were submitted to DHCS on 09/11/2024.

- Improving Well Child Visits in the First 15 Months of Life (W30-6) Equity PIP, focused on the Black/African-American Population in Solano County:
  - Partnership piloted an intervention with newborns born at NorthBay Medical Center, the only hospital in Solano County that is open to Medi-Cal members. The intervention focuses on the use of navigators assisting these families in enrolling in the Growing Together Program, completing the Newborn PCP Selection Form, and ensuring that they have begun the Medi-Cal enrollment process for their newborns.
  - Cycle 1 of the pilot is complete. Cycle 2 will continue the intervention with newborns born at NorthBay as part of Population Health's post-partum follow-up outreach, and also explore opportunities to add other L&D units in proximity to Solano County to the pilot.
- Improving the Percentage of Provider Notifications for members with Serious Mental Health (SMH) Diagnosis within 7 Days of Emergency Department (ED) Visit.

	○ Partnership is piloting an intervention with Open Door Community Health Centers to increase rates for follow-up visits for members with a recent ED visit with a mental health diagnosis. ○ Partnership and Open Door began work on Cycle 1 in September 2024. Open Door will use ED alerts that they receive via their Epic OCHIN EMR to track, schedule, and complete follow up visits with members. Partnership will verify that the visit coding results in closed care gaps for the FUM measure. Best practices from Cycle 1 have potential to be spread to other provider organizations using Epic. *DHCS Comprehensive Quality Improvement (QI) & Health Equity (HE) Process* • Based on MY2022 HEDIS performance, DHCS assigned Partnership additional accountability work in 2024 focused on the Behavioral Health, Children's Health, and Reproductive Health and Cancer Prevention measure domains. This work, called the Comprehensive Quality Improvement and Health Equity Process, has required Partnership to define strategies and action plans for 2024 to improve HEDIS rates in the included domains. • Partnership submitted progress reports to DHCS on strategies and action items to improve HEDIS measure performance on 10/25/2024. • In late December, Partnership received a request from the DHCS Quality team to meet this month to review MY2023 HEDIS annual performance and how it will impact our 2024 strategies and actions, as we enter 2025. • An overview of 2024 strategies and actions underway for improving performance by measure domain include: Children's Health: ○ Development of data reporting that will be reviewed with providers highlighting missed opportunities (i.e. episodes where patients were seen via an office visit, but preventative services were not completed) to capture pediatric services, such as well child visits. ○ Analysis of the issue of delayed newborn Medi-Cal enrollment's impact on claims capture for the Well Child Visit Birth – 15 Months measure and design of interventions to expedite newborn Medi-Cal enrollment. Behavioral Health Domain: ○ Collection of County Department of Public Health data around Follow-Up Visits for ED Visits with a Mental Health Diagnosis using the Sacramento Valley MedShare Health Information Exchange to improve real-time visibility of ED visits, specialty mental health encounters, and outpatient visits. ○ Piloting the use of embedded Community Health Workers in several EDs within Partnership's network to complete referrals for Partnership members presenting with a mental health or substance use diagnosis. Reproductive Health and Cancer Prevention Domain:

	○ Improving breast cancer screening rates in imaging center deserts, using mobile mammography events and interventions with imaging centers with significant access challenges. ○ Piloting the use of chlamydia home screening kits with a partner provider(s).
QUALITY MEASURE SCORE IMPROVEMENT	*HPV 2nd Dose Reminder Mailers Pilot Project* • The pediatric workgroup launched a pilot project aimed at improving IMA scores by increasing HPV vaccine series completion rates. • The workgroup has identified a list of 767 members who are due for their 2nd dose of the HPV vaccine. These members are assigned to 58 unique practices across all counties. • Mailers reminding members that they are due for this vaccine were sent out to each member on the list early December. A new distribution list will be generated each month for 3 more months. The impact of these mailers will be evaluated in May 2025. *WCV Disparity Sprint Project* • Six provider organizations worked diligently through year-end to conduct well child visits for prioritized disparity populations identified by DHCS. Updated gap lists were sent mid-December to show which visits have been captured since the sprint began on 10/01/2024. Partnership will complete a final refresh after the end of December so that the participating providers can submit any final claims before the sprint deadline of 01/31/2024. *Healthy Babies* Growing Together Program *(GTP) Provider Promotion* • The pediatric workgroup, in collaboration with Population Health, has successfully expanded promotion of the new Healthy Babies GTP to providers via Northern Regional Provider meetings and Joint Leadership Initiative meetings. Additionally, promotion of GTP will be cited as best practice during the upcoming *Improving Measure Outcomes: Pediatric Preventive Care* webinar and added to the 2025 Measure Best Practices available on the Improvement Academy page. The pediatric workgroup leads and Pop Health will be tracking GTP enrollment numbers. Promotion of GTP has also been extended to Provider Relations where they will provide flyers and offer information regarding GTP to their respective sites. *Retinal Camera Grants* • Partnership is preparing to launch a limited grant opportunity to fund diabetic retinopathy cameras for practices located in optometry deserts. Partnership will be hosting an introduction webinar to select practices to outline the program and share successes from a provider who has successfully implemented retinal cameras.
IMPROVEMENT ACADEMY	2025 Improvement Academy registration links are posted on Partnership's website. All trainings are open to providers throughout the 24-county network and include: • An ABCs of Quality Improvement in-person training in Ukiah on 01/30/2025.

	• The 2025 Improving Measure Outcomes webinar series will cover Partnership's Primary Care Provider Quality Incentive Program (PCP QIP) measures. Content will focus on direct application of best practices including eliminating health disparities with examples from clinical quality improvement teams who are doing the work. Planned sessions include: ○ 02/10/2025 - Pediatric Preventative Care for Ages 0 - 30 Months ○ 02/26/2025 - Pediatric Preventative Care for Ages 3 - 17 years ○ 03/12/2025 - Chronic Disease and Colorectal Cancer Screening ○ 03/26/2025 - Perinatal Care and Chlamydia Screening ○ 04/09/2025 - Breast and Cervical Cancer Screenings ○ 04/23/2025 - Diabetes Control • First Microlearning on ePrompts is in development, set to launch January 2025. ePrompts is accessible via Provider Online Services and reflects gaps in care from many PCP QIP measures. This member-level information can be leveraged readily by provider staff conducting eligibility checks and appointment scheduling. It is also visible to members using Partnership's Member Portal.
JOINT LEADERSHIP INITIATIVE (JLI)	• Fall Sessions have concluded. JLI program strategy team will meet early next year to evaluate the program and map out 2025 JLI parent organizations.
REGIONAL IMPROVEMENT MEETINGS	• The next sessions will be held in quarter one of 2025.

Note: Detailed information and recordings of Performance Improvement related webinars are posted to the PHC Website:
http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE
STATE MANDATED WORK: EQUITY AND PRACTICE TRANSFORMATION (EPT) PROGRAM	• The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative with the goal of advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC). • Partnership received $1,526,085.49 in Initial Planning Incentives Payments (IPIP) funding. ○ $10,000 was awarded to twenty-three (23) qualifying provider organizations through the IPIP program. The IPIP is geared toward small and medium-sized independent practices to support their planning and application process for the Provider Directed Payment Program (PDPP). ○ The EPT strategy team continues to explore utilization for the remaining IPIP funds. A subset of funds will be allocated to tribal

	health organizations to support improvement efforts. More information will follow as plans for the allocation of funds continue to develop. • All twenty-seven (27) provider organizations, who were invited by DHCS to participate in the PDPP, sent acceptance responses to DHCS by the 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. The accepted provider organizations are spread across each of Partnership's sub-regions, including five (5) provider organizations contracted with Partnership from the 2024 - 10 county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's Enhanced Provider Engagement (EPE) program. DHCS has recalculated the final award amounts, due to budget revisions. ○ PHLC anticipates distributing the EPT Milestone Deliverable Report this month. The report will provide a summary of submitted EPT deliverables by practice. ○ EPT practices that did not complete the below 2024 deliverables on 11/01/2024 have until 11/01/2025 to submit as a requirement to remain enrolled in the program: ▪ Empanelment and Access Milestone 1: Empanelment Assessment ▪ Empanelment and Access Milestone 2: Empanelment Policy and Procedure ▪ Data to Enable Population Health Management (PHM) Milestone 1: Data Governance and HEDIS Reporting Assessment and Data Governance Policy and Procedure. ○ The next EPT submission period will open on 05/01/2025. PHLC has yet to announce what additional deliverables will be due. ○ DHCS is operationalizing EPT payments now until February 2025. MCPs should receive EPT payment(s) from DHCS by March 2025 which are due to be sent to the EPT practices by April 2025. • The Statewide Learning Collaborative (SLC) is meant to support practices awarded the PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP. ○ To remain in the EPT program, practices will need to demonstrate 80% attendance in the Practice Track and Learning Community sessions of the EPT Technical Assistance. ○ PHLC is looking for 3 - 5 EPT practices to participate on the EPT Guidance Committee. The Guidance Committee will provide feedback and suggestions on the development, design, and delivery of EPT Technical Assistance (TA).

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EPT practices have until 01/06/2025 to notify PHLC at info@pophealthlc.org of their interest.

The EPT Practice Level Reporting Specifications are noted below for MCPs to use as a guide for the 01/31/2025 submission.

<table>
<tr><td>Measurement Period</td><td>January 1 - December 31, 2023</td></tr>
<tr><td>Data Source</td><td>HEDIS MY2023 Medi-Cal administrative rates or, if available, ECDS rates</td></tr>
<tr><td>Attribution</td><td>Attribute patients as of anchor date to EPT practices for any given measure, as defined by the HEDIS MY2023 technical specs</td></tr>
<tr><td>Data Fields</td><td>Denominator, Numerator, Rate for each measure</td></tr>
<tr><td>Measures</td><td>All EPT HEDIS measures, across all Populations of Focus</td></tr>
<tr><td>Practices</td><td>All contracted – not only sponsored – EPT practices</td></tr>
<tr><td>File Format</td><td>.xlsx or .csv</td></tr>
<tr><td>Submission by</td><td>Email data file to info@pophealthlc.org</td></tr>
</table>

The EPT PM Team will work with the HEDIS team to complete the EPT Practice Level Reporting Template and pull numerator, denominator, and rates of all EPT HEDIS-like measures for Partnership contracted EPT practices.

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<tr><td>CAPACITY ENHANCEMENT GRANTS</td><td>

For the first time in Partnership’s 30-year history, contract negotiations were not fulfilled prior to the expiration of a provider contract. Dignity Health’s contract termination affected over 64,000 members in Nevada, Shasta, Siskiyou, Tehama, and Yolo counties for several weeks in April through June. In response to this disruption, the Capacity Enhancement Grant (CEG) was created and offered to providers who agreed to take member assignments previously with Dignity Health.
The CEG Program closed upon the distribution of the second and final installment of funding totaling $1,441,857.50.
Evaluation of the program is in progress.

</td></tr>
<tr><td>LOCUM PILOT INITIATIVE</td><td>
The QI Locum Pilot Initiative was developed as a short-term solution to provide access to clinicians with the goal of improving HEDIS performance in preventative care, specifically well-child visits and cervical cancer screenings. This offering is designed as a limited Grant Program, whereby participating Provider Organizations are granted funds to select and hire a Locum Tenens Provider for a 4-week period.

A total budget of $250,000 was approved; participating providers receive up to $45,000 when hiring a Physician; or $31,600 when hiring an Advanced Practicing Clinician.
The Grant is paid out in two installments:

1st installment upon signing the Agreement, 50% of eligible funds
2nd installment upon completing the 4-week assignment and post-program survey, remaining 50%

The initial cohort of providers was selected from those participating in the PCP Modified QIP. Six (6) offers to apply were made and four applications were received. All four (4) applications were accepted.

</td></tr>
</table>

- Locum assignment periods were carried out asynchronously through the end of 2024. Weekly Provider check-ins and data collection have been conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment.
- Thus far, we are learning Locum Providers are alleviating a backlog of well-child and adolescent visits. Locum Providers are also covering urgent care needs, allowing patients to schedule visits with their preferred physician.
- Hill Country Community Clinic initially hired a locum who was unable to fulfill the requirements of the position. A new locum started on December 2nd and after completing 40 hours of onboarding, started seeing patients. Weekly check-ins will continue as their efforts are tracked.
- Round Valley Indian Health has expressed a renewed interest in recruiting for a locum to provide services through this grant program. An informal weekly check-in with their HR representative will take place to monitor their progress; it is likely an extension to the grant agreement will be needed.
- Community Medical Center completed the initial grant activities and has been awarded an extension; their locum will be funded through the end of 2024 to continue focusing on well-child visits, including disparity groups.
- Pit River Health Service has completed the grant activities and final evaluation. The clinic was able to increase access and see 218 patients, primarily well-child visits.

Provider Organization	Total Award	Locum Assignment and Status
Hill Country Community Clinic	$31,600	A Nurse Practitioner locum started December 2nd and will continue grant activities through the end of 2024.
Pit River Health Service	$31,600	Grant activities and final evaluation have been completed, successfully completing 218 patient visits.
Round Valley Indian Health	$45,000	Renewed efforts to recruit for a locum.
Community Medical Center	$31,600	Expanded grant activities sponsored through Dec. 2024. Continued WCV focus, including identified disparity groups.

QUALITY MEASURE SCORE IMPROVEMENT MOBILE MAMMOGRAPHY PROGRAM

- Between 07/01/2024 to 12/31/2024, Partnership sponsored 43 Mobile Mammography event days with 23 provider organizations at 38 provider sites.

<table>
<tr><td></td><td>
<table>
<tr><th colspan="5">Completed Event Days
07/01/2024 – 12/31/2024</th></tr>
<tr><th>Legacy Region</th><th># of Provider Organizations</th><th># of Provider Sites</th><th># of Event Days</th><th># of Completed Partnership Screenings</th></tr>
<tr><td>ER</td><td>6</td><td>13</td><td>15</td><td>181</td></tr>
<tr><td>NE</td><td>7</td><td>8</td><td>10</td><td>235</td></tr>
<tr><td>NW</td><td>2</td><td>7</td><td>8</td><td>170</td></tr>
<tr><td>SE</td><td>2</td><td>3</td><td>3</td><td>75</td></tr>
<tr><td>SW</td><td>7</td><td>7</td><td>7</td><td>145</td></tr>
<tr><td>Plan Wide</td><td>23</td><td>38</td><td>43</td><td>806</td></tr>
</table>

Two (2) event days in the Northwest Region were held at a Tribal Health Center in Humboldt County.
One (1) event day in the Northeast Region was held at a Tribal Health Center in Trinity County.
One (1) event day in the Southwest Region was held at a Tribal Health Center in Mendocino County.
Three (3) event days in the Eastern Region were held at a Tribal Health Center in Tehama County.
Scheduling for Mobile Mammography events for Q3 (January – March 2025) is currently in progress.

</td></tr>
<tr><td>Partnering for Pediatric Lead Prevention Program</td><td>The program has transitioned from a round-based application process to an ongoing, continuous application period. This means applicants will no longer need to wait for specific rounds to apply. Instead, they can submit applications at any time. We have updated all materials to reflect this new approach and developed a targeted promotional strategy aimed at reaching low-performing participants who have not applied in the past.</td></tr>
<tr><td>QI Trilogy Program</td><td>Mid-Year status updates for the 2024-2025 QI Work Plan were received by Business Owners on 01/16/2025.
Initial notices for the 2025-2026 QI Program Description will be emailed to Business Owners on 02/10/2025. Submissions are due 03/03/2025.</td></tr>
<tr><td>Consumer Assessment of Healthcare Providers and Systems® (CAHPS) Program</td><td>The CAHPS® regulated survey for Measure Year (MY) 2024 / Report Year (RY) 2025 will start in February and conclude in May 2025.
Partnership will formally submit the Child population for the National Committee for Quality Assurance (NCQA) Health Plan Rating in MY 2024 / RY 2025.
The CAHPS® team is leaning into lessons learned through the administration of the MY 2023 / RY 2024 Non-Regulated Drill-Down Adult survey by preparing future survey tools (core/custom question development,</td></tr>
</table>

	reporting criteria linked to plan and HEDIS Quality Compass benchmark performance) for both the Adult and Child populations. • Discussions regarding timing for administering another Non-Regulated Drill Down survey for MY 2024 / RY 2025 are currently underway. • FY 2024/2025 Organizational Goal, Access to Care and Member Experience Improvements – Status update: Milestone 8 - *The Member Experience (ME) Workgroup will collaborate with the Quality Improvement Pay-for-Performance (QIP) team to explore Unit-of-Service measure development opportunities* - COMPLETE. o Outcome: Due to numerous measure changes, the PCP QIP Technical Workgroup decided to offer an alternative solution for 2025. The measure specification has been updated. The goal workgroup developed a resource and provider education document designed to inform and influence Patient/Member Experience activities. The PCP QIP MY 2025 Specifications will now include a URL resource link within the Patient Experience Unit-of-Service measure description. • The Medicare CAHPS program is in development. Interviews with sister plans have been conducted and relationships established for ongoing exchanges to help inform the buildout. • CMS approved survey vendors have been identified and RFIs were sent. The CAHPS team will conduct in-depth discussions with the two vendors that responded and consider whether a formal RFP will be necessary to identify and move forward with the preferred vendor. We will be prepared to contract with a vendor mid-2025.
GEOGRAPHIC EXPANSION: QI PROGRESS	• All Geo Expansion Project Plan activities are complete except for the following: o Joint Leadership Initiative (JLI): Auburn/Chico region participation included Ampla Health in 2024. Adventist Health sites in the expansion region were integrated with their organization's established JLI. Final MY2024 PCP QIP performance and member assignment volumes will inform additional JLI participation in 2025. o Regional Collaboration: A regional forum will be developed once the recently hired PI manager for the Auburn/Chico region is announced and active in the role. o Equity and Practice Transformation (EPT): The program concludes in 2026 and there are seven (7) expansion practices active.

PARTNERSHIP ADVANTAGE (D-SNP)

ACTIVITY	UPDATE
MODEL OF CARE	• The Model of Care has received a mock-review score of 91% overall. Contributors will complete final edits by 01/03/2025 and the document will

	be handed over to the Quality Project Management team for formatting on 01/06/2025. The document will be submitted to RAC on 01/20/2025.
STARS STRATEGY	• The HEDIS Stars Strategy interdepartmental workgroup continues to meet monthly to execute data capture and analysis for the potential D-SNP population. The workgroup is developing an interdepartmental strategy to approach data visibility in the coming year.
PROJECT PLANS	• The Quality Department has completed initial project outlines for all D-SNP related projects scheduled through the end of the 2025 calendar year. Tasks will be updated monthly and shared with the Medicare Operations Committee and the Medicare Program Manager.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **11/30/2024 TO 12/29/2024**	• PQI referrals received during this period: 18. 13 of these cases were referred from Grievance and Appeals, two from Pharmacy, one from Utilization Management, and two from other sources. • Two PQI cases were reviewed at the Peer Review Committee. • 18 cases were processed and closed to completion. • Focused Review: 1 case is currently being reviewed. • PQI cases that are currently open: 94 cases
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: 10/28/2024 TO 12/27/2024	• As of 12/30/2024, Partnership is responsible for conducting site reviews across a total of 455 PCP and OB sites, with an additional 31 reviews required due to multiple patient check-ins within larger sites. In total, this requires managing a total of 486 periodic site reviews. **Primary Care and OB Reviews:**

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
Auburn	4	5	0	3
Chico	8	4	1	3
Eureka	10	9	0	4
Fairfield	0	0	0	0
Redding	1	1	1	1
Santa Rosa	1	1	1	1

New sites opened this period →
- Chico – Ampla Health Family Dental & Medical
- Eureka – Eureka Health Center

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	• The HEDIS MY2024 Annual Audits are scheduled: ○ DHCS Managed Care Accountability Set (MCAS) – 02/13/2025 ○ NCQA Health Plan Accreditation (HPA) – 02/26/2025

	• Preparation is underway to receive and integrate all data to support the HEDIS MY2024 regulatory required reporting; this includes all non-standard supplemental data sources that will require Primary Source Verification (PSV), which must be approved by both auditors. • A special W30+6 medical record review (MRR) project is scheduled to launch as part of the MCAS annual project in mid-January 2025 and will conclude by 02/28/2025. This special project is focused on retrieving, abstracting, and overreading compliant medical records to supplement the W30+6 administrative rate for MY2024. • Continued preparation is underway to begin plan-wide reporting as required by both DHCS MCAS and NCQA HPA HEDIS auditors in MY2024 reporting. • Additionally, beginning in MY2024, County-Level Reporting directly to DHCS will be completed for all 24 counties using the over-sampling methodology recently communicated by DHCS in late 2024.
HEDIS® Program Overall	• On 12/06/2024 DHCS issued monetary sanctions to Partnership for performance below the Minimum Performance Level (MPL) on measures within MY2023 MCAS. The total sanction amount was $475,000. Partnership has developed a formal appeal through legal counsel on MY2023 sanctions, which was submitted to an administrative law judge before 12/31/2024. Partnership is challenging over 80% of the $475k sanction being imposed. • On 12/20/2024, Partnership submitted written notification to DHCS citing several sources of incomplete data for which we are reliant on them for complete and accurate performance reporting on MY2024 MCAS measures. Our internal analysis has identified significant data gaps in MY2024 for dental, newborn enrollment, substance use disorder, and specialty mental health data, which DHCS sends to Partnership via the Plan Data Feed. Partnership will continue to monitor these data sources for completeness and communicate status to DHCS. • DHCS has also shared a plan to sanction Managed Care Plans (MCPs) at the county level for MCAS measure performance below the MPL beginning in MY2024. As a MCP with a 24-county network, Partnership would be uniquely burdened by this proposed sanction methodology. Furthermore, many Partnership counties would not have a cohort of members for many measures that would meet NCQA's threshold for a statistically significant sample size to measure, or base sanctions upon. Partnership has escalated concerns of statistical validity and analyzed its MY2023 results to demonstrate the flawed methodology in the design of these proposed county-level sanctions.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA)	• Partnership has selected Managed Healthcare Resources (MHR) as the new NCQA Consultant with a start date of January 2025. MHR provides a team approach, and three (3) consultants will be assigned to Partnership. MHR consultants will respond to email questions without document reviews within two (2) business days; however, larger document reviews will need to be scheduled to ensure appropriate time is allowed. The NCQA Program Management Team will have an onboarding session with MHR on 01/08/2025 and will provide a list of documents that will require a review in Q1 2025. In 2025, MHR's focus will be on HPA and will support both HPA and HEA beginning in 2026. The current consultant, Williams Consulting, will continue consulting with Partnership through December 2025; however, her focus will be on HEA and the HEA Initial Survey scheduled in June 2025. • NCQA releases policy updates to both the HPA and HEA Standards and Guidelines three (3) times a year in November, March, and July. These triannual policy updates can include a correction, clarification, policy change, or regulatory change. The NCQA Program Management Team incorporated the November 2024 updates into the current HPA and HEA Standards and Guidelines with tracked changes and shared the updates with the applicable Business Owners. Business Owners have reviewed and submitted their acknowledgement of the policy updates.
NCQA Health Equity Accreditation (HEA)	• In preparation for Partnership's HEA Initial Survey scheduled for 06/17/2025, Business Owners are required to submit their annotated and bookmarked evidence by 03/28/2025. The NCQA Program Management Team will host an evidence preparation training session on 01/23/2025. Business Owners are asked to follow the plan-wide preparation instructions to ensure consistency in Partnership's evidence to streamline the review by the NCQA surveyors. The NCQA Program Management Team will provide Business Owners with Evidence Submission Trackers specific to their assigned standards with submission instructions by 01/31/2025.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)

Consent Calendar

Jan. 15, 2025

Items on the Consent Calendar have minor or no changes and are recommended by staff for approval.

[1] *The new alphanumeric reflects the policies moving from UM (MCUP) to Enhanced Health Services (MCHP).*

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2024 ANNUAL OVERSIGHT AUDIT
Carelon

December 3, 2024

NOTICE OF FINAL AUDIT RESULTS

January 1, 2023 – December 31, 2023

Attention:
Kaneisha Willis, AP Regional Operations

Dear Kaneisha,

Partnership Health Plan of California (PHC) writes this notice to advise you regarding the conclusion of this year's annual delegation compliance oversight audit. As a result of the supplemental documentation and feedback we received from your organization, you will find the final audit results on the next page. Each of the finalized CAP forms for the preliminary deficiencies we reviewed during the audit also attached with this notice for your records.

This year's **audit scope** is outlined below:

SCOPE AREA	REVIEW TYPE	CURRENT CAP STATUS
Care Coordination	**Program Review**	**0-CAP**
Claims/PDR (PD/Denied)	**Program/File Review**	**0-CAP**
Compliance	**Program Review**	**0-CAP**
Credentialing	**Program Review**	**0-CAP**
Cultural& Linguistic	**Program Review**	**0-CAP**
Finance (Prop 56)	**Program Review**	**0-CAP**
Grievance and Appeal	**Program Review**	**0-CAP**
Mental Health Services	**Program Review**	**0-CAP**
Member Services	**Program Review**	**0-CAP**
Net Management	**Program Review**	**0-CAP**
Quality Improvement/QIPQI	**Program Review** Special Review (Identification, Reporting and Processing of PQI)	**0-CAP**
Utilization Management	**Program/File Review**	**0-CAP**
Basic Case Management	**Program Review**	**0-CAP**

Please be advised that the completion of this annual audit does not preclude any future PHC auditing or oversight activities, and should not be construed as a substitute for any other reviews required by law, license, or accreditation. PHC values the services provided to our members by Carelon and we look forward to a continued partnership.

If you have any further questions or concerns, feel free to contact me directly.

Sincerely,

Charo Patio
Compliance Auditor
Regulatory Affairs and Compliance Department
Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534
Phone: (707)863-4288 |**FAX:** (70)450-7568
Email: cpatio@partnershiphp.org
Normal work hours: 8 a.m-5p.m Monday –Friday (note: I am off every other Friday)
Our website: www.partnershiphp.org
PHC Mission: *To help our members, and the communities we serve, be healthy*
cc: Kenzie Hanusiak, Dani Ogren

2024 ANNUAL OVERSIGHT AUDIT
Carelon

December 3, 2024

FINAL AUDIT RESULTS REPORT

January 1, 2023 – December 31, 2023

RECOMMENDATIONS/COMMENTS: *The following description(s) address opportunities for improvement, as observed during audit, and does not represent a formal finding or request for corrective action plan. PHC will review cited opportunities for improvement through monitoring and future oversight audits. Recommendations that require collaboration will be initiated by PHC.*
N/A
N/A

ASSIGNED CAPs: *Any preliminary deficiencies, which have not been justified or corrected, result in a formal Corrective Action Plan (CAP). Every CAP listed below must be satisfied and closed by the given deadline. Should there be any justifiable reason that The Delegate needs additional time or would like to discuss a CAP further, please let us know immediately.*

SCOPE AREA	DEFICIENCY/CAP DESCRIPTION	INSTRUCTION TO CLOSE	DEADLINE
n/a			

Partnership HealthPlan of California

Referral Follow-up Monitoring Report for January 2024 IQI and QUAC meeting

Data analysis for January 1, 2023 through June 30, 2024

Background:

Who requires a referral for specialty care? Partnership members who are capitated or assigned to a primary care provider (PCP) must generally have a referral authorization (RAF) submitted electronically by the PCP in order to see a specialist. For in-network referrals within Partnership's large specialty provider network, no additional prior authorization is needed from PHC. Non-contracted providers (including those specialists who are not enrolled in State Medicaid) are reviewed for medical necessity and for member proximity according to the standards set by Partnership's policy MCUP3124 *Referral to Specialists*.

Direct Members, members who are American Indians or qualified family members, and members enrolled in the California Children's Services/Whole Child Model Program may be referred by the PCP without completion of a RAF, or they may see a specialist directly, without a referral. This includes members with Medicare primary insurance or other commercial primary insurance. Since other payers are the primary insurance, we have little data on the use of these services for these patients. In addition, members seen in the emergency department with fractures or other serious acute orthopedic issues do not require prior authorization.

What does Partnership data show?

A detailed analysis of specialty access, including interventions to address specialty access priorities is presented annually through the over-/under-utilization workgroup, and included into the overall Access and Availability NCQA Grand Analysis.

Some highlights:

Most common specialty appointments by number of visits (claims year to date for 2024)

Continued next page:

Year: 2024, Specialty: All, Region: All, Mbr County: All, Age: All, Aid Cat: All, Insurance: All, Gender: F & M, Homeless: All

	Number of Visits	Utilizing Members	Avg. Visits per member	% of Total Visits
OBSTETRICS/ GYNECOLOGY	65,654	25,393	2.6	14%
PSYCHIATRY	43,720	15,950	2.7	10%
ORTHOPEDIC SURGERY	34,613	21,326	1.6	8%
CARDIOVASCULAR DISEASE/INTERN..	32,272	22,148	1.5	7%
OPHTHALMOLOGY	26,493	18,458	1.4	6%
DERMATOLOGY	25,385	17,517	1.4	6%
ONCOLOGY/HEMATOLOGY	24,397	10,438	2.3	5%
PAIN MANAGEMENT	22,228	8,182	2.7	5%
GENERAL SURGERY	17,638	12,303	1.4	4%
PULMONARY DISEASE	16,590	10,409	1.6	4%
NEUROLOGY	13,227	9,956	1.3	3%
OTOLARYNGOLOGY	13,211	9,980	1.3	3%
GASTROENTEROLOGY	11,543	9,198	1.3	3%
PODIATRY - DPM	11,358	7,256	1.6	3%
ENDOCRINOLOGY	10,772	6,929	1.6	2%
EMERGENCY MEDICINE	10,648	8,333	1.3	2%
UROLOGY	10,058	7,276	1.4	2%
NEPHROLOGY	7,922	5,424	1.5	2%
PHYSICAL MEDICINE AND REHABILIT..	7,535	3,482	2.2	2%
RHEUMATOLOGY	5,528	3,486	1.6	1%
MISCELLANEOUS	5,447	2,380	2.3	1%
ALLERGY/ IMMUNOLOGY	4,937	3,521	1.4	1%
PERIPHERAL VASCULAR DISEASES O..	3,278	2,319	1.4	1%
PEDIATRIC CARDIOLOGY	2,822	2,289	1.2	1%
CHIROPRACTIC - DC	2,818	1,456	1.9	1%
NEUROLOGY (CHILD)	2,527	1,909	1.3	1%
NEUROSURGERY	2,334	1,936	1.2	1%
INFECTIOUS DISEASES	2,127	1,482	1.4	0%

Overuse of specialists compared to a “Well-managed benchmark” shows trends over time for major specialties. This is an indication of access for different specialists in different counties:

Year of Service Date
2024

Ratio against Well-managed benchmark by Specialty

	2024																							
	BUTTE	COLU..	DEL NORTE	GLENN	HUM..	LAKE	LASSEN	MARIN	MEND..	MODOC	NAPA	NEVA..	PLAC..	PLUM..	SHAS..	SIERRA	SISKI..	SOLA..	SONO..	SUTT..	TEHA..	TRINI..	YOLO	YUBA
RHEUMATOLOGY	41%	39%	72%	18%	64%	44%	61%	34%	63%	60%	107%	71%	51%	17%	44%		55%	59%	75%	19%	16%	31%	37%	29%
DERMATOLOGY	34%	6%	35%	22%	32%	28%	9%	11%	33%	4%	62%	31%	29%	12%	14%	41%	11%	48%	35%	16%	256%	6%	26%	17%
ALLERGY/ IMMUNOLOGY	40%	6%	16%	6%	37%	28%	21%	26%	32%		128%	2%	5%		5%		5%	57%	43%	4%	4%	8%	43%	2%
OTOLARYNGOLOGY	45%	21%	62%	40%	23%	55%	17%	25%	27%	23%	54%	17%	34%	8%	26%	27%	14%	27%	38%	22%	30%	12%	21%	21%
UROLOGY	52%	403%	29%	44%	27%	59%	11%	41%	45%	35%	111%	19%	24%	26%	29%	69%	17%	45%	44%	23%	26%	26%	24%	18%
ENDOCRINOLOGY	86%	94%	69%	56%	31%	24%	39%	46%	34%	35%	62%	51%	46%	12%	28%	73%	63%	81%	39%	59%	23%	17%	55%	42%
GASTROENTEROLOGY	77%	42%	51%	41%	24%	79%	10%	74%	74%	14%	129%	51%	46%	18%	35%	88%	18%	99%	67%	41%	27%	40%	53%	41%
NEUROLOGY	76%	91%	28%	54%	48%	35%	52%	45%	34%	52%	57%	43%	34%	51%	83%	95%	39%	48%	37%	90%	45%	40%	35%	70%
PULMONARY DISEASE	165%	115%	47%	133%	39%	100%	44%	64%	166%	36%	88%	255%	131%	328%	112%	266%	48%	130%	139%	105%	83%	87%	53%	133%
ORTHOPEDIC SURGERY	54%	19%	57%	42%	41%	40%	38%	55%	69%	33%	70%	47%	25%	56%	70%	114%	75%	48%	50%	18%	32%	71%	25%	23%
ONCOLOGY/HEMATOLOGY	80%	84%	61%	90%	59%	102%	33%	71%	76%	18%	147%	64%	77%	55%	42%	67%	24%	179%	117%	76%	65%	56%	56%	53%
CARDIOVASCULAR DISEASE/INTERNAL MEDICINE	138%	201%	43%	110%	44%	145%	62%	125%	96%	44%	160%	29%	47%	44%	75%	71%	42%	100%	117%	73%	63%	107%	38%	58%
NEPHROLOGY	122%	167%	37%	240%	27%	92%	43%	64%	41%	117%	216%	57%	46%	55%	43%	338%	43%	113%	64%	144%	808%	48%	39%	85%
OPHTHALMOLOGY	613%	108%	67%	194%	105%	190%	50%	65%	215%	135%	361%	39%	48%	32%	136%	146%	55%	172%	89%	64%	105%	108%	51%	65%
GENERAL SURGERY	88%	62%	191%	133%	146%	197%	101%	102%	206%	80%	122%	42%	38%	59%	77%	69%	140%	65%	89%	31%	82%	62%	43%	38%

The referral monitoring Tableau report shows the specialties where referrals are made, in order of descending number, with the percentage of claims/RAFs listed, along with the number of days between the date of the RAF and the date of service.

Overall, the percentage of claims/referrals was 51% in the first half of 2024, compared to 59% in 2023, 60% in 2022, 62% in 2021, 62% in 2020, 59% in 2019, 59% in 2018, and 55% in 2017. Due to claims lag, and a historical trend for lower volume of referrals in the first half of the year vs. the second half of the year, this RAF utilization percentage for 2024 appears comparatively lower than annual trends. Of note, on January 1, 2024, ten additional counties were added to the Partnership County Organized Health Plan. The Primary Care Providers and Specialists have been becoming accustomed to Partnership's systems in this first year, as it differed from the system of the prior commercial managed care plans. However, as noted below, the use of referrals is similar in the new Eastern Region compared to the more established Southern Region.

In the past year, several specialists retired or left our service region without being replaced. A relative shortage of providers leads to a PCP to submit extra referrals per patient to find a specialist willing to accept the patient. This shortage of specialists is more pronounced in the Northern Region, where the percentage of referrals utilized is lowest, supporting this hypothesis.

Of the referrals that resulted in a claim, the average number of days between the referral and the date of service was 42 days in the first half of 2024, compared to 59 days in 2023, 58 days in 2022, 51 days in 2021, 48 days in 2020, 47 days in 2019, 45 days in 2018, and 42 days in 2017. The decrease in the time to appointment in 2024 is notable, with many potential causes (provider education campaigns, improved fidelity of PCP referral patterns, etc.). At this time no one factor can be proven to be dominant.

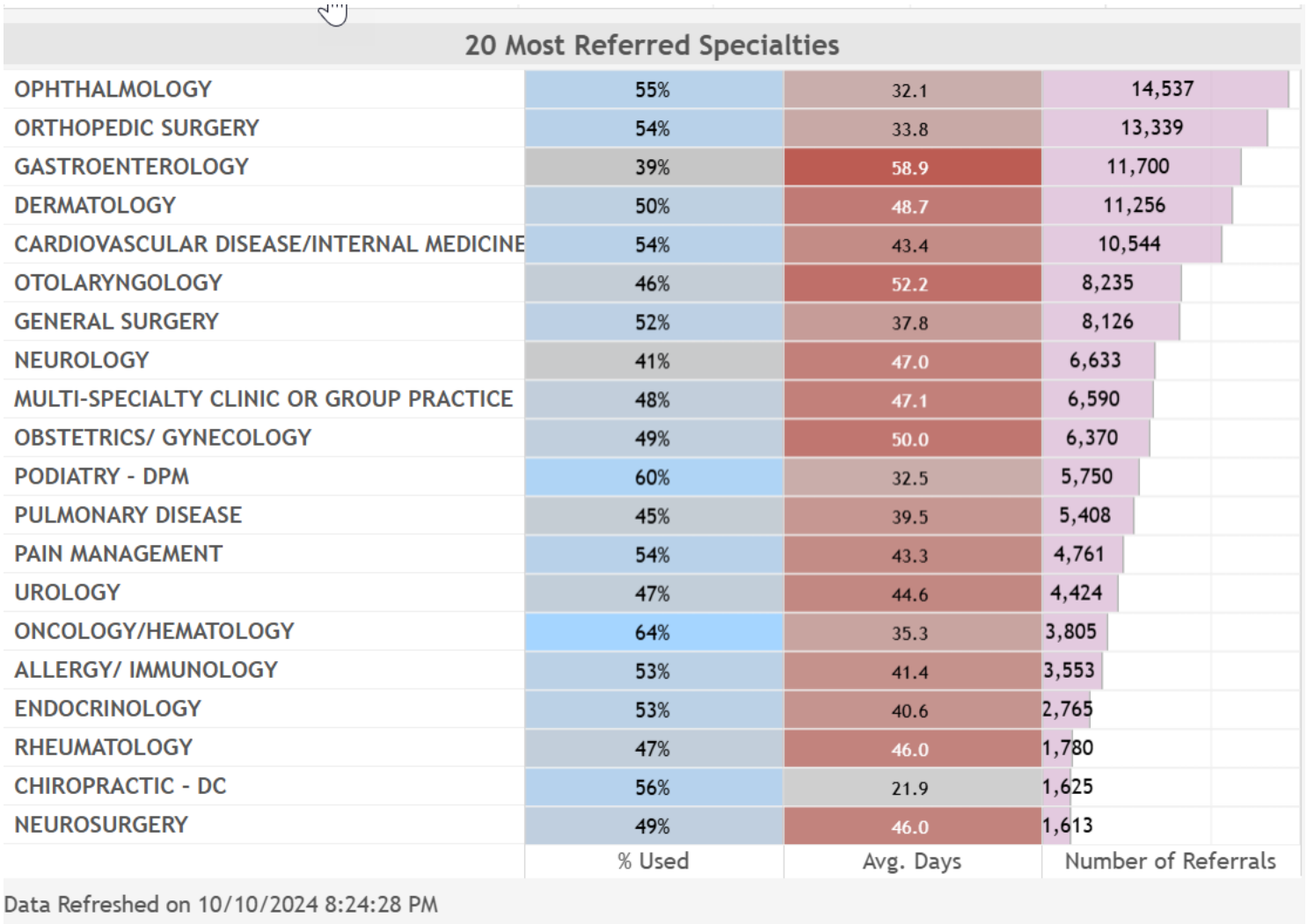
Here is the summary of RAFs submitted in the first six (6) months of 2024:

Overview

	EASTERN	NORTHERN	SOUTHERN	Grand Total
Number of Referrals	43,878	31,841	70,159	145,878
% RAFs Used	52%	47%	52%	51%
% Out of Network	2.6%	1.6%	0.3%	1.3%
Avg. Days to Appt	43.2	41.3	40.5	41.5
Median Days to Appt	30	27	26	28

NOTE: The higher percentage of out of network specialists in the Northern and Eastern Regions is due to the use of specialists in Southern Oregon and Reno, Nevada, who are closer in proximity to the frontier counties of Del Norte, Modoc, Lassen, Plumas, Sierra, northern Siskiyou, eastern Nevada, and eastern Placer than to the closest specialists in California.

The table below shows the percentage of RAFs that resulted in a claim and the average days between the RAF being entered and the date of service for a claim for the highest volume specialties for the first half of 2024:



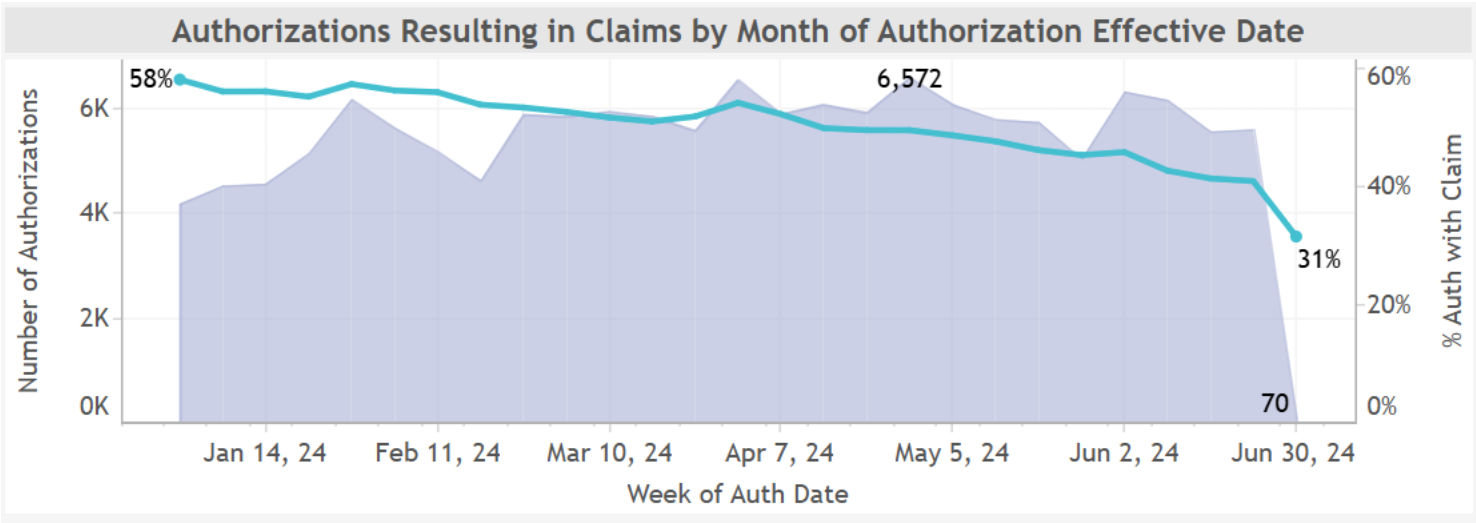
20 Most Referred Specialties

	% Used	Avg. Days	Number of Referrals
OPHTHALMOLOGY	55%	32.1	14,537
ORTHOPEDIC SURGERY	54%	33.8	13,339
GASTROENTEROLOGY	39%	58.9	11,700
DERMATOLOGY	50%	48.7	11,256
CARDIOVASCULAR DISEASE/INTERNAL MEDICINE	54%	43.4	10,544
OTOLARYNGOLOGY	46%	52.2	8,235
GENERAL SURGERY	52%	37.8	8,126
NEUROLOGY	41%	47.0	6,633
MULTI-SPECIALTY CLINIC OR GROUP PRACTICE	48%	47.1	6,590
OBSTETRICS/ GYNECOLOGY	49%	50.0	6,370
PODIATRY - DPM	60%	32.5	5,750
PULMONARY DISEASE	45%	39.5	5,408
PAIN MANAGEMENT	54%	43.3	4,761
UROLOGY	47%	44.6	4,424
ONCOLOGY/HEMATOLOGY	64%	35.3	3,805
ALLERGY/ IMMUNOLOGY	53%	41.4	3,553
ENDOCRINOLOGY	53%	40.6	2,765
RHEUMATOLOGY	47%	46.0	1,780
CHIROPRACTIC - DC	56%	21.9	1,625
NEUROSURGERY	49%	46.0	1,613

Data Refreshed on 10/10/2024 8:24:28 PM

The percentage of referrals used ranged from 39% for Gastroenterology to 64% for Heme/Onc.

The trend over time is relatively stable, with a slight decrease over time, when sufficient time for claims to be submitted is allowed for. The steadiness of the trend supports the most likely cause as PCPs casting a wider net for specialty needs, with multiple specialist referrals for a single patient to increase the likelihood of finding a specialists willing to see the patient.



The specialties with longer lengths of time from RAF approval to date of service are generally the same specialties that the Telehealth team has identified as having access challenges n our geographic service area.

Improvement of the Primary Care Referral Process

As noted earlier, Partnership performs an Access and Accessibility NCQA Grand Analysis, which incorporates this data into its annual analysis of access and accessibility.

Standing activities to promote an effective specialty referral process at our health centers includes the following:

1. Coordinating "Referral Coordinator Roundtables" where referral coordinators from primary care sites interact with local referral coordinators from specialist offices to solve problems and improve efficiencies within the referral process.
2. Vigorously supporting telemedicine and eConsult programs to decrease the need for PCPs to refer patients to specialists, and
3. Support of transportation of members to needed appointments.

Monitoring of Referral Process

- Sample of member referrals: Partnership monitors referral documentation of individual members in its triennial Medical Record audits of PCP sites. Corrective action plans may be required if documentation or follow-up is lacking. Rates of CAPs for this finding cannot be reported due to limitations in our electronic capture of MRR results.

- PCP Tracking of Referral Completion Rates: PCPs are responsible for coordinating the referral process for their patients. If they have challenges finding a specialist, or if the member has transportation difficulties, PCPs are urged to reach out to the Partership Care Coordination team for assistance.

To ascertain the underlying reasons why some RAFs do not result in a claim, a sample of high referral rate PCPs submit referral tracking reports from their Electronic Health Record (HER) systems (i.e., EPIC), for referrals made in the first six (6) months of 2024. The reports from EPIC are more helpful for analysis of disposition of referrals. Two providers using EPIC are presented below. Many large PCPs have converted to EPIC, and this trend is anticipated to continue going forward into the coming year. This should make additional data available in future analyses.

1. Open Door Community Health Centers (Humboldt and Del Norte Counties)

JANUARY through JUNE 2024- Referrals ordered PHC/CHDP ONLY

OD ARCATA	733
OD DEL NORTE	845
OD EUREKA	2880
OD FERNDALE	139
OD FORTUNA	930
OD HUMBOLDT	744
OD MCKINLEYVILLE	885
OD NORTHCOUNTRY	665
OD PSNC OB	179
OD REDWOOD	1369
OD TELEHEALTH & VISITING SPEC	486
OD WILLOW CREEK	353
Blank	5
Grand Total	**10,213**

Ordered Referrals-January - June 2024

Ordering Error- Physician Canceled	461	5%
Incomplete- Pending additional testing	35	0%
Not yet resulted -Authorized and Open	1969	19%
Resulted- Closed	7748	76%
Grand Total	**10213**	**100%**

Resulted Referrals-January - June 2024

(blank)	3	3	0%
Denied - Capacity Limits	7	166	2%
Denied - Ineligible for Services	71		
Denied Other	74		
Denied Per Provider	14		
Declined Service	232	1373	18%
DNA (Did Not Attend)	823		
Patient Cancelled	40		
Incomplete Per Patient	1		
Unable to reach the patient	1		
Moved Out of Service Area	14		
No Response from Provider	86		
No Response Letter/Phone	176		
Processed, no need to obtain report	1185	1307	17%
No Support Needed	122		
Patient Completed Referral Elsewhere	11	4774	62%
Referral Complete Result Not Received	33		
Results in Care Everywhere	1365		
Results Received	3365		
Voided- Ordering Error	125	125	2%
Grand Total	**7748**	**7748**	**100%**

NOTE: Open Door updated their analysis methodology in 2024 to account for referrals by each Open Door network PCP site, as well as to provide for further drill-down on outcomes of closed referral requests. For historical reference, the percentage of denied referrals was 9% in 2019, 5% in 2020, 2% in 2021, 3% in 2022, 4% in 2023, and 2% in 2024. In recent years, the supply of specialists in Humboldt County has become more constrained. A specific intervention was carried out in early 2021 to address the relatively high rate of denials by specialists, which has contributed to stabilization of this trend.

2. Petaluma Health Center (Sonoma County)

Petaluma Health Center: External Referral Closed Reason from 01-01-2024 to 06-30-2024		
	Count of #	**Count of #2**
Authorized	757	8.30%
Canceled	278	3.05%
Closed	7979	87.47%
Denied	90	0.99%
New Request	16	0.18%
Pending Review	2	0.02%
Grand Total	9122	100.00%

Petaluma Health Center: External Referral Closed Reason from 01-01-2024 to 06-30-2024		
	Count of #	**Sum of #**
No Response from Provider	5	0.07%
Results Received	6	0.05%
No Longer Needed	22	0.30%
Declined Service	33	0.39%
Misc. Reason	34	0.48%
Denied	41	0.48%
Unable to reach the patient	58	0.92%
Closed by Correction	75	0.93%
Results in Care Everywhere	145	2.26%
No Contact	264	4.43%
Scheduled	286	3.76%
Patient Cancelled	397	3.57%
Complete	530	8.04%
Referral Expired	667	7.88%
Not Specified	2097	22.95%
Appt Request - Auto Closed	3319	43.49%

NOTE: Denial rate for Petaluma Health Center for referrals within Sonoma County and immediate surrounding counties are lower than Open Door rate.

3. Santa Rosa Health Center (Sonoma County):

Santa Rosa Health Center: External Referral Status from 01-01-2024 to 06-30-2024

	Count of #	Count of #2
Authorized	1339	13.58%
Canceled	221	2.24%
Closed	7807	79.15%
Denied	22	0.22%
Incomplete	6	0.06%
New Request	405	4.11%
Open	5	0.05%
Pending Review	58	0.59%
(blank)		0.00%
Grand Total	9863	100.00%

Santa Rosa Health Center: External Referral Closed Reason from 01-01-2024 to 06-30-2024

	Count of #	Count of #2
Moved Out of Service Area	5	0.06%
Patient Cancelled	8	0.10%
Denied	34	0.44%
No Response from Provider	37	0.47%
Scheduled	44	0.56%
No Support Needed	47	0.60%
3rd Call Non-Compliant	52	0.67%
Declined Service	61	0.78%
No Longer Needed	119	1.52%
Closed by Correction	247	3.16%
Misc. Reason	357	4.57%
No Contact	538	6.89%
Complete	554	7.10%
Results Received	990	12.68%
Not Specified	1312	16.81%
Results in Care Everywhere	1529	19.58%
Referral Expired	1873	23.99%

NOTE: Denial rate consistent with Petaluma Health Center

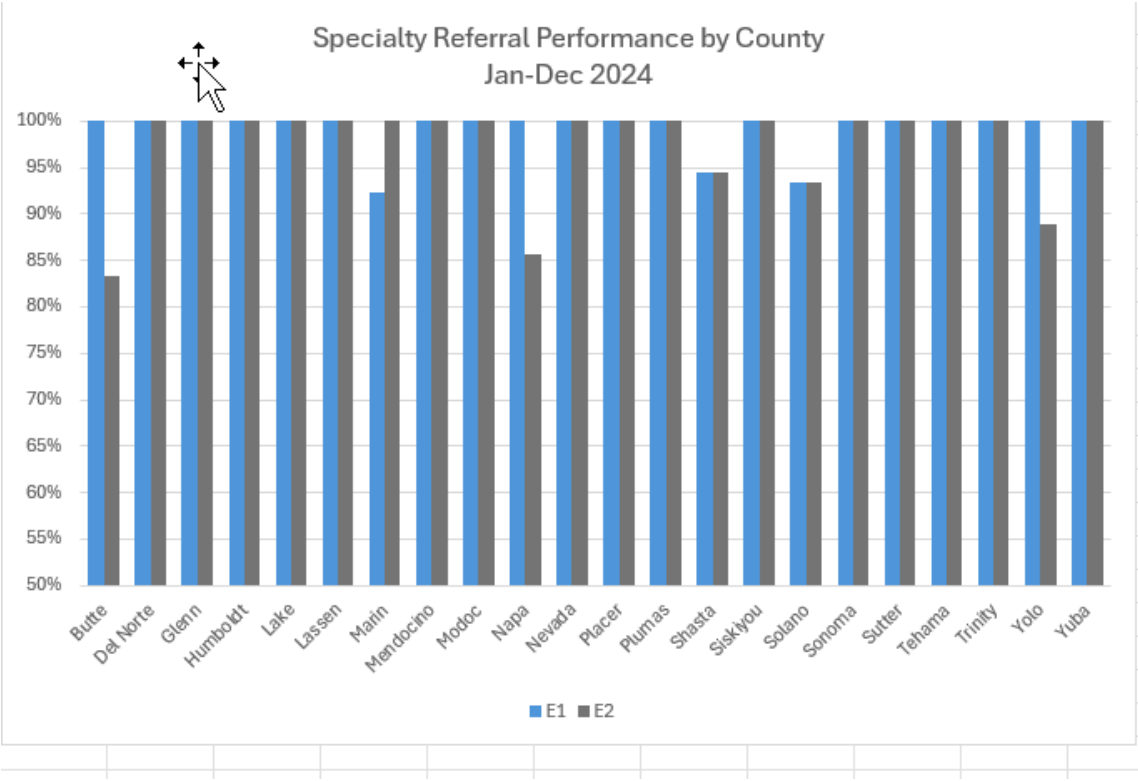
4. La Clinica, Vallejo (Solano County)

PHC ONLY Patients Internal and Outgoing Referrals Jan-Jun 2024		
Referral Status	**Sum of Number**	**Percentage**
Authorized	1	0.02%
Closed	3768	56.53%
Denied	1	0.02%
Incomplete	32	0.48%
New Request	865	12.98%
Open	1915	28.73%
Pending Review	84	1.26%
Grand Total	6666	100.00%

NOTE: The denial rate in Vallejo is lower than Petaluma Heath, Santa Rosa Health, and Open Door

Chart audits of follow-up after referrals:

Partnership audits contracted primary care sites for follow-up after referral as part of the site review process, which occurs at least triennially. The table below details the results of these audits for site reviews conducted in 2024:



County	E1	E2
Butte	100%	83%
Del Norte	100%	100%
Glenn	100%	100%
Humboldt	100%	100%
Lake	100%	100%
Lassen	100%	100%
Marin	92%	100%
Mendocino	100%	100%
Modoc	100%	100%
Napa	100%	86%
Nevada	100%	100%
Placer	100%	100%
Plumas	100%	100%
Shasta	94%	94%
Siskiyou	100%	100%
Solano	93%	93%
Sonoma	100%	100%
Sutter	100%	100%
Tehama	100%	100%
Trinity	100%	100%
Yolo	100%	89%
Yuba	100%	100%

Key:

OM_E: Office Management: Office practice procedures allow timely provision and tracking of:

1. Processing internal and external referrals, consultant reports, and diagnostic test results.
2. Physician review and follow-up of referral/consultation reports and diagnostic test results.

Historically, overall compliance in the site reviews is excellent. An important caveat is that the site review tool combines the follow-up of referrals and laboratory/imaging results not a combined result. As evidenced in the report, while sites almost universally report a process for ensuring physician review of reports and results, the medical record review audit showed that about three (3) quarters of sites complied with their policy. Sites that are not compliant are educated on the standard and may be subject to completion of a corrective action plan.

Conclusions: When referrals are not completed by the member/patient, in organizations with careful tracking systems, multiple different reasons account for lack of completion of referrals. Providers are reminded in provider newsletters, in-person meetings and at referral roundtables of their responsibilities to manage the referral process and reach out to Partnership when problems are encountered. Most challenges encountered by PCPs are related to the general lower level of specialists practicing in our more rural areas. Use of telemedicine and e-consult in these areas is being aggressively supported to mitigate these shortages. These and other interventions are detailed in the Access and Availability Grand Analysis.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPQP1018 (previously QP100118)</td><td colspan="2">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Preventive Health Guidelines</td><td colspan="2">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 05/17/2000</td><td colspan="3">Next Review Date: ~~02/14/2025~~02/12/2026
Last Review Date: ~~02/14/2024~~02/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage [1]</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~02/14/2024~~02/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCQG1005 – Adult Preventive Health Guidelines
B. MCQG1015 – Pediatric Preventive Health Guidelines
~~B.~~C. MCUG3118 – Prenatal & Perinatal Care

II. IMPACTED DEPTS.:

A. Health Services
B. Provider Relations
C. Member Services
D. Claims
~~A.~~E. Network Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

Preventive Health Guidelines assist the practitioner to remove or reduce disease risk factors and promote early detection of disease or precursor states.

VI. POLICY / PROCEDURE:

Preventive Health Guidelines consist of standards for pediatric, adult, and perinatal care. These standards are to serve as a guideline and are not necessarily recommended at every periodic visit. The services may be performed during visits for other reasons, like illness visits or chronic disease checkups, when indicated. Medically necessary services and supplies required for preventive health care are covered when ordered and performed by the Primary Care Practitioner or Obstetrician/Gynecologist.

A. The Preventive Health Guidelines are developed by the Partnership HealthPlan of California (Partnership) Health Services department using input from like-specialty providers and evidence-based recommendations including but not limited to:

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules.

Policy/Procedure Number: MPQP1018 (previously QP100118**)**			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Preventive Health Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/17/2000			**Next Review Date: 02/12/2026** **Last Review Date: 02/12/2025**
Applies to:	☐**Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

1. Pediatrics:
   a. American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care – Periodicity Schedule
   b. Centers for Disease Control and Prevention – U.S. Preventative Services Task Force
2. Obstetrics:
   a. American College of Obstetricians and Gynecologists (ACOG)
   b. U.S. Preventive Services Task Force
3. Adult:
   a. U.S. Preventive Services Task Force
   b. American Academy of Family Physicians (AAFP)
   c. American College of Obstetricians and Gynecologists (ACOG)
   d. American College of Physicians (ACP)

B. The Preventive Health Guidelines are presented to the Quality/Utilization Advisory Committee (Q/UAC) and to the Physicians Advisory Committee (PAC) for review, revision if needed, and approval at least annually, and more frequently if major changes occur.
C. The Preventive Health Guidelines are included in the Facility Site Review (FSR) tool.
D. The Preventive Health Guidelines are available on the Partnership website. The Guidelines are distributed to new practitioners upon entering the plan and annually thereafter. The Provider Relations department is responsible for the distribution of Preventive Health Guidelines.
E. The Provider Manual is updated as changes occur. At the discretion of Partnership's Internal Quality Improvement (IQI) Committee, a broadcast bulletin may also be done by Provider Relations.
F. Highlights of the Preventive Health Guidelines, with a link to the comprehensive recommendations, will be reviewed annually in the member newsletter.

VII. REFERENCES:

A. American Academy of Pediatrics (AAP) 2024~~3~~ Recommendations for Preventive Pediatric Health Care
B. American College of Obstetricians and Gynecologist (ACOG)
C. American Academy of Family Physicians (AAFP)
D. American College of Physicians (ACP) Clinical Practice Guidelines and Recommendations
E. U.S. Preventive Services Task Force (USPSTF)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
05/16/01; 07/17/02; 10/20/04; 03/15/06; 03/21/07; 03/19/08; 04/16/08; 03/18/09; 03/17/10; 05/18/11; 08/15/12; 08/21/13; 08/20/14; 08/19/15; 09/21/16; 10/18/17; *10/10/18; 02/13/19; 02/12/20; 02/10/21; 02/09/22; 02/08/23; 02/14/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Policy/Procedure Number: MPQP1018 (previously QP100118**)**			**Lead Department: Health Services** Business Unit: Quality Improvement
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Applies to:	☐**Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

Partnership*Advantage*:
MPQP1018 - 03/21/07 to 01/01/2015

Healthy Families:
MPQP1018 - 08/15/2012 to 03/01/2013 (Healthy Families program ended 12/01/2016)

Healthy Kids
MPQP1018 - 03/21/07; 03/19/08; 04/16/08; 03/18/09; 03/17/10; 05/18/11; 08/15/12; 08/21/13; 08/20/14; 8/19/15; 09/21/16 to 12/01/16 (Healthy Kids program ended 12/01/2016)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1038				**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Physician Orders for Life-Sustaining Treatment (POLST)				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 08/28/2008			**Next Review Date:** ~~02/14/2025~~02/12/2026 **Last Review Date:** ~~02/14/2024~~02/12/2025		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage** [1]	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~02/14/2024~~02/12/2025	

I. RELATED POLICIES:
N/A

II. IMPACTED DEPTS:
A. Health Services

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. California Physician Orders for Life-Sustaining Treatment (POLST) Revised Form effective April 1, 2017 and available at: https://capolst.org/.

V. PURPOSE:
To establish Partnership HealthPlan of California's policy for use of the Physician Orders for Life-Sustaining Treatment (POLST) form.

VI. POLICY / PROCEDURE:
The Physician Orders for Life-Sustaining Treatment (POLST) is a physician order sheet. The POLST translates a person's wishes for medical treatment at the end of life into a set of physician orders that are followed throughout the medical system, including during transport between medical facilities. It constitutes a uniform document which implements a person's wishes in all health care settings.

A. The POLST is not an Advance Directive and does not take the place of one. Patients should still be encouraged to complete an Advance Directive if they do not have one. The POLST translates the Advance Directive into physician orders. It also replaces the emergency medical services (EMS) form that gives resuscitation directions to emergency response staff in a patient's home or any residential care facility.
   1. The POLST is optional and not required. It can be an alternative to the "Pre-Hospital Do Not Resuscitate," "Preferred Intensity of Care" and "Preferred Intensity of Treatment" forms, although

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules.

POLST is more comprehensive in that it addresses other life-sustaining treatment in addition to resuscitative measures.

2. The primary population for completion of a POLST form is anyone with a life-limiting illness who is appropriate for end-of-life planning. However, the POLST form is valid for any patient.
3. The POLST may be changed by the patient, surrogate decision-maker (if patient is incapable of expressing their wishes), or the physician.
4. Effective January 1, 2016, a physician, nurse practitioner, or physician assistant must sign the POLST. It also should be signed by the patient or legally recognized decision-maker.
5. If the possibility of resuscitation arises (patient has no pulse and no respiration), Part A: Attempt Resuscitation or Do Not Attempt Resuscitation orders are followed.
6. If any section of the POLST is not completed, the highest level of treatment must be provided until further discussion with physician, nurse practitioner, or physician assistant. As with other physician orders, new orders can supersede the initial POLST.
7. The physician, nurse practitioner, or physician assistant will be notified if the patient or legally recognized decision-maker requests a change in the POLST treatment decisions.
8. In the skilled nursing setting, the POLST may be used in place of other facility cardiopulmonary resuscitation (CPR) treatment decision forms; dual forms are not necessary.

B. Recommendations for completing a POLST form with the patient:
1. If the patient or surrogate decision maker chooses to complete a POLST form, the physician, nurse practitioner, or physician assistant or designated staff member will discuss the treatment options in the POLST form. Discussion will also include the patient's Advance Directive (if done) or other statements the patient has made regarding their wishes for end of life care and treatments. The likelihood of treatment success and the potential for causing suffering should be discussed when deciding upon CPR and medical interventions. Additional information about medical interventions is available for patients and families in the POLST Patient Handout.
2. The POLST form is completed according to the patient's expressed wishes.
3. The physician, nurse practitioner, or physician assistant and the patient or his/her legally recognized decision-maker will sign the POLST form.
4. The POLST instructions and form are available in PHC's threshold languages, including Spanish, Russian, and Tagalog. See capolst.org/polst-for-healthcare-providers/forms/.

C. Review of POLST form:
1. The physician, nurse practitioner, or physician assistant and patient or legally recognized decision-maker may review or revise the POLST at any time.
2. During care plan conferences or discharge planning, the physician may review the POLST to see if the patient's condition warrants review or revision.
3. The POLST can also be marked "VOID" and a new POLST completed. The original POLST marked "VOID" should be signed and dated. A copy of POLST marked "VOID" is kept in medical record directly behind the current POLST.
4. As the patient moves from one health care setting to another or to home, the most current, original POLST form (including copies of any Advance Directive) should accompany the patient.

D. Recommendations for when a patient with a POLST form is admitted to a health care facility:
1. The physician, nurse practitioner, or physician assistant, nurse, social worker or designated staff member will review the contents of the POLST form with the patient or surrogate decision maker.
2. POLST orders will be honored by the staff. Resuscitation orders will be transcribed into the patient's medical orders.
3. If the POLST is signed by a physician, nurse practitioner, or physician assistant who is not a member of the medical staff, POLST orders will be followed until reviewed by a credentialed member of the medical staff. POLST orders are continued, unless the attending physician writes new orders.

Policy/Procedure Number: MPQP1038			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Physician Orders for Life-Sustaining Treatment (POLST)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/28/2008		**Next Review Date:** ~~02/14/2025~~02/12/2026 **Last Review Date:** ~~02/14/2024~~02/12/2025	
Applies to:	☐**Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

~~4.~~ The POLST form is copied for the medical record (or scanned into the electronic medical record).

5. At the time of discharge, the Discharge Summary should note that patient has a POLST form. The original POLST should be sent with the patient at discharge or transfer from the facility.

VII. REFERENCES:

California Physician Orders for Life-Sustaining Treatment https://capolst.org/

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
08/19/09; 11/17/10; 10/17/12; 10/16/13; 10/15/14; 10/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19, 02/12/20; 02/10/21; 02/09/22; 02/08/23; 02/14/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

PartnershipAdvantage:
MPQP1038 - 08/20/2008 to 01/01/2015

Healthy Families:
MPQP1038 - 11/17/2010 to 03/01/2013

Healthy Kids (Healthy Kids program ended 12/01/2016)
MPQP1038 - 08/28/08; 08/19/09; 11/17/10; 10/17/12; 10/16/13; 10/15/14; 10/21/15; 01/20/16 to 12/01/16

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2017)*

First follow these orders, then contact Physician / NP / PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	Preparer Name (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCCP2018 (previously MPUP3004, UG100304)</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Advice Nurse Program</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 01/04/1995</td><td colspan="4">Next Review Date: ~~02/14/2025~~02/12/2026
Last Review Date: ~~02/14/2024~~02/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~02/14/2024~~02/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3039 - Direct Members
B. MCUP3014 - Emergency Services
C. MCUP3044 – Urgent Care Services
D. CMP36 – Delegation and Oversight Monitoring

II. IMPACTED DEPTS:

A. Health Services
B. Member Services
C. Claims

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

~~To describe and define the scope and guidelines for services provided by the Partnership HealthPlan of California (PHC) sponsored Advice Nurse Program.~~To describe and define the scope and guidelines for services provided by the Partnership HealthPlan of California (Partnership) sponsored Advice Nurse Program.

VI. POLICY / PROCEDURE:

A. Partnership~~HC~~ ~~has~~ contracts with an Advice Nurse Program to provide after-hours services. This service is offered to those members who are assigned to primary care providers (PCPs) who agree to participate in the program and for all Direct Members.
B. The Partnership~~HC~~ Advice Nurse Program is intended for use by members after normal business hours of their PCP, both to optimize quality of care and to reduce unnecessary emergency department usage.
C. The Advice Nurse Program is not intended to replace or substitute for physician availability to respond to calls from their members that originate through the physician's answering service.
D. PCP practices that choose to participate in the program should instruct their answering service how to assist members in contacting the Advice Nurse Program.
E. A member may still utilize the program even if their PCP elects not to participate in the Partnership~~HC~~ Advice Nurse Program.

F. All PCPs participating in the Advice Nurse Program must be willing to accept the nationally accepted protocols established by the Advice Nurse Program and approved by Partnership~~HC~~.

G. Advice Nurse Program Procedures
   1. The advice nurses function under nationally recognized medical protocols ~~established by McKesson~~ and pediatric triage guidelines established by Schmitt Pediatric Guidelines LLC. Protocols and triage guidelines are reviewed and approved by Partnership~~HC~~ on an annual basis with a sample audit to ensure they are current and accurate.
   2. The advice nurse notifies the Partnership~~HC~~ Care Coordination Department by fax regarding the nature of medical problem calls. Care coordination interventions are initiated according to need.
   3. Emergency situations:
      a. The advice nurse advises the member to go to an Emergency Room and calls 911 if appropriate.
      b. The advice nurse sends a copy of the completed medical screening form to Partnership~~HC~~ and the PCP on file if listed.
   4. Urgent situations:
      a. The advice nurse assesses the problem and triages the patient to an Emergency Room, Urgent Care facility or to the PCP office according to the pre-established protocol.
      b. The advice nurse sends a copy of the completed medical screening form to Partnership~~HC~~ and the PCP on file if listed.
   5. Non-Urgent situations:
      a. The advice nurse gives advice per the appropriate agreed upon protocol and advises the member to follow-up with PCP.
      b. The advice nurse sends a copy of the completed medical screening form to Partnership~~HC~~ and the PCP on file if listed.
   6. Education only:
      a. The advice nurse provides the member with general health education per the agreed upon protocol.

H. Delegation Oversight and Monitoring
   1. Partnership~~HC~~ delegates the administration of the Advice Nurse Program to a vendor.
   2. A formal agreement is maintained and inclusive of all delegated functions.
   3. Oversight and monitoring activities include, but are not limited to the following, and occur no less than annually:
      a. Audit of delegated entity(ies) to ensure utilization of nationally accepted protocols.
      b. Chief Medical Officer (CMO) or physician designee conducts review of policies and procedures and medical protocols.
      c. In accordance with California B&P Code Section 4999.2 and the California Department of Consumer Affairs, Partnership~~HC~~ ensures personnel and/or vendors are registered or licensed healthcare professionals in California.
      d. The Chief Health Services Officer and designee review monthly activity reports provided by the delegated entity and will document any notable findings and/or variances and ensure the appropriate corrective action plans are in place, as appropriate.
      e. Review monthly reports provided by delegated entity~~ie~~(ies) which summarize the number and disposition of calls from Partnership~~HC~~ members to the Advice Nurse Program.
   4. Results from Oversight and Monitoring activities are presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval and reviewed by the CMO or physician designee.
   5. Partnership~~HC~~ ~~will~~ holds joint operating meetings with the Advice Nurse Program quarterly or as needed.

Policy/Procedure Number: MCCP2018 (previously MPUP3004, UG100304)			**Lead Department: Health Services** Business Unit: Care Coordination
Policy/Procedure Title: Advice Nurse Program			☒ **External Policy** ☐ **Internal Policy**
Original Date: 01/04/1995		**Next Review Date:** 02/12/2026 **Last Review Date:** 02/12/2025	
Applies to:	☐**Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

VII. REFERENCES:

A. Schmitt-Thompson Guidelines 2024~~3~~: Nurse triage guidelines for adult and pediatric
B. California Business and Professions Code Section 4999.2 and the California Department of Consumer Affairs

VIII. DISTRIBUTION:

A. Partnership~~HC~~ Department Directors
B. Partnership~~HC~~ Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

MCCP2018 (01/18/2017)
*02/14/18; 03/13/19; 03/11/20; 03/10/21; 03/09/22; 03/08/23; 02/14/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Medi-Cal (UG100304, MPUP3004)
10/10/97 [name change only]; 06/01/2000, 10/17/01; 10/16/02; 10/20/04; 10/19/05; 10/17/07; 10/15/08; 11/18/09; 04/21/10; 01/19/11; 04/17/13; 01/21/15; 01/20/16 to 01/18/17

Healthy Kids MPUP3004 (Healthy Kids program ended 12/01/2016)
10/17/07; 10/15/08; 11/18/09; 04/21/10; 01/19/11; 04/17/1; 01/21/15; 01/20/16 to 12/01/2016

Healthy Families
MPUP3004 - 10/01/2010 to 03/01/2013

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership~~HC~~ to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership~~HC~~.

Partnership~~HC~~'s authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="3">Policy/Procedure Number: MCCP2031</td><td colspan="3">Lead Department: Health Services
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<tr><td colspan="3">Policy/Procedure Title: Private Duty Nursing under EPSDT</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 09/09/2020</td><td colspan="4">Next Review Date: ~~02/14/2025~~02/12/2026
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I. RELATED POLICIES:

A. MCCP2022 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
C. MPCR 12 – Credentialing of Independent and Private Duty Nurses under EPSDT
D. MCUP3041 – Treatment Authorization Request (TAR) Review Process
E. MCUP3106 – Waiver Programs
F. MCUG3011 – Criteria for Home Health Services

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Member Services
D. Claims

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. DHCS: Department of Health Care Services
C. EPSDT: Early and Periodic Screening, Diagnostic, and Treatment
D. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services and home health care services for in-home visits by a provider. In California, this is known as CalEVV.
E. Home Health Agency (HHA): An HHA is a state-licensed public or private organization that provides in-home skilled nursing services.
F. Individual Nurse Provider (INP): An individually enrolled Medi-Cal provider acting within their scope of practice (Registered Nurse or Licensed Vocational Nurse) to provide private duty nursing services.
G. Medical Necessity for EPSDT Services: For individuals under 21 years of age, a service is medically necessary or a medical necessity if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services
H. Private Duty Nursing (PDN): Nursing services provided in a member's home by a registered nurse (RN) or licensed vocational/practical nurse (LVN) for a member who requires more individual and continuous care than what would be available from a visiting nurse.
~~I. PHC: Partnership HealthPlan of California~~
~~J.~~ Whole Child Model (WCM): In participating counties, this program provides comprehensive treatment

Policy/Procedure Number: MCCP2031		Lead Department: Health Services Business Unit: Care Coordination	
Policy/Procedure Title: Private Duty Nursing under EPSDT		☒ External Policy ☐ Internal Policy	
Original Date: 09/09/2020		**Next Review Date:** 02/12/2026 **Last Review Date:** 02/12/2025	
Applies to:	☐ Employees	☒ Medi-Cal	Partnership Advantage

for the whole child and care coordination in the areas of primary, specialty, and behavioral health for any Partnership HealthPlan of California (Partnership) pediatric members with a CCS-eligible condition(s).~~A comprehensive program for the whole child encompassing care coordination in the areas of primary, specialty, and behavioral health for any pediatric member insured by PartnershipHC.~~

~~K.~~I.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

~~To define Partnership HealthPlan of California's (PHC's) responsibility to provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Service Benefit for shift nursing and case management assistance to appropriate members under the age of 21. Under the Federal EPSDT Supplemental Services Program, Federal law [(Title 42, USC, Section 1396(a)(43) and 1396d(r)] requires that state Medicaid plans provide coverage for any service that is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition for beneficiaries under 21 years of age even if the service or item is not otherwise included in the state's Medicaid plan. For some members under the age of 21, Private Duty Nursing (PDN) services may be medically necessary.~~ To define Partnership HealthPlan of California's (Partnership's) responsibility to provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Service Benefit for shift nursing and case management assistance to appropriate members under the age of 21. Under the Federal EPSDT Supplemental Services Program, Federal law [(Title 42, USC, Section 1396(a)(43) and 1396d(r)] requires that state Medicaid plans provide coverage for any service that is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition for beneficiaries under 21 years of age even if the service or item is not otherwise included in the state's Medicaid plan. For some members under the age of 21, Private Duty Nursing (PDN) services may be medically necessary.

VI. POLICY / PROCEDURE:

A. Partnership~~HC~~ will cover and ensure the provision of screening, preventive and medically necessary diagnostic health care services and treatment for members under the age of 21 in accordance with the EPSDT program benefit. For more information on EPSDT services, please see Partnership~~HC~~ policy: MCCP2022 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.

B. Requests for private duty nursing (PDN) services are authorized through licensed and Medi-Cal certified Home Health Agencies (HHAs) or an individually enrolled Medi-Cal provider known as an Individual Nurse Provider (INP) acting within their scope of practice (registered nurses and/or vocational nurses). INPs must meet Partnership~~HC~~'s credentialing policy guidelines. For more information, see Partnership~~HC~~ policy: MPCR12 Credentialing of Independent and Private Duty Nurses Under EPSDT.

C. Partnership~~HC~~ participates in the California Children's Services (CCS) Whole Child Model (WCM) program. As such, PDN services for CCS eligible conditions are reviewed and approved by Partnership~~HC~~ under EPSDT. For more information on the Whole Child Model, see Partnership~~HC~~ policy: MCCP2024 Whole Child Model for California Children's Service (CCS).

~~1. Beginning January 1, 2024, the collaboration between the California Children's Services (CCS) program and the Partnership HealthPlan of California (PartnershipHC) is an adjunct to the county specific Memorandum of Understanding (MOUs). The counties included are Tehama, Plumas, Glenn, Butte, Colusa, Sutter, Yuba, Sierra, Nevada, and Placer. Please refer to MPCP2002 – California Children's Services.~~

~~2. These CCS counties will follow their usual process of authorizing services for CCS related conditions.~~

D. Partnership~~HC~~ maintains the responsibility to provide comprehensive case management services and authorize all medically necessary covered services for members accepted into a waiver program.

PartnershipHC will coordinate with the appropriate agency and/or program to ensure members are connected to the appropriate services. For more information, see PartnershipHC policy MCUP3106 Waiver Programs.

E. REQUESTS FOR PRIVATE DUTY NURSING:

PartnershipHC will review and authorize medically necessary shift nursing services for members under the age of 21 in accordance with CCR, Title 22, section 51340(e) and the following criteria:

1. All requests are subject to prior authorization requirements.
2. The services must be prescribed by the member's primary care provider or provider of record for the diagnosed condition(s).
3. Members must have FULL SCOPE Medi-Cal Benefits. In instances where members have other health coverage or benefits available for shift nursing care, those benefits and resources must be utilized first in accordance with Medi-Cal program guidelines.
4. Requests for services are made through licensed and Medi-Cal certified HHAs or a PartnershipHC credentialed INP.
5. Services must be provided in the home, which has been assessed to be a safe, healthy environment by the requesting home health provider.
6. Requests for the use of Home Health Aide services must be made through a licensed HHA and are subject to documented physician orders and medical necessity. The Home Health Aide must be an employee of the agency, and as such, is subject to appropriate oversight in the care of the member.
7. The family and/or primary caregiver should be proficient in the tasks necessary to care for the member at home to ensure care is not interrupted should an unforeseen event occur. This proficiency may be satisfied by active participation and training as necessary to safely carry out the plan of care, and by the caregiver(s) providing four (4) or more hours of direct care to the member per week in order to maintain their skills. In keeping with this requirement, PartnershipHC reserves the right to limit hours as follows:
   a. Limit approved skilled nursing care provided by a Home Health Agency (HHA) to a maximum of 22 hours/day, and/or
   b. Limit approved skilled nursing care provided by an Individual Nurse Provider (INP) to a maximum of 11 hours/day per INP
8. The Treatment Authorization Request (TAR) and required documentation must be submitted to PartnershipHC Health Services within 15 days from the date of service, please see PartnershipHC Policy MCUP3041 Treatment Authorization Request (TAR) Review Process for more information. The following documentation is required at the time of the request for shift nursing services:
   a. Completed TAR form
   b. Current Nursing Plan of Care
   c. Current Physician Progress Notes
   d. Home Safety Assessment
   e. Emergency Plan
   f. Report(s) of initial assessment
   g. Daily notes for Home Health Aid/ RN oversight (when applicable)
9. Other documentation that may be requested to clarify specific issues and/or medical necessity include, but are not limited to the following:
   a. Current History and Physical (H&P) with full system review
   b. Social Worker Assessment
   c. Regional Center Assessment
   d. A Needs Assessment completed by an Individual Nurse Consultant
   e. Staff timesheets
   f. Evidence or denial or exhaustion of any shift nursing benefit from other health coverage, if applicable.

10. Upon receipt of the TAR with supporting documentation for medical necessity, PartnershipHC may authorize initial requests for shift nursing services for up to 90 days. Subsequent authorizations will be 180 days or as appropriate.

F. Electronic Visit Verification (EVV) Requirements:
1. Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal personal care services and home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
2. Please refer to policy MCUG3011 Home Health Services for further information on EVV requirements.

G. Case Management
1. PartnershipHC is responsible for providing case management services to our members. "Case Management Services" means those services furnished to assist individuals eligible under the Medi-Cal State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 Code of Federal Regulations (CFR) sections 441.18 and 440.169. The assistance that case managers provide in assisting eligible individuals is set forth in 42 CFR section 440.169(d) and (e), and 22 California Code of Regulations (CCR) section 51184(d), (g) (5) and (h).
2. "EPSDT services" means Early and Periodic Screening, Diagnostic and Treatment services, a benefit of the State's Medi-Cal program that provides comprehensive, preventative, diagnostic, and treatment services to eligible children under the age of 21, as specified in section 1905(r) of the Social Security Act. (42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).)
3. “Home Health Agency" as defined in Health and Safety Code section 1727(a) and used herein, means a public or private organization licensed by the State which provides skilled nursing services as defined in Health and Safety Code section 1727(b), to persons in their place of residence.
4. "Individual Nurse Provider" or "INP" means a Medi-Cal enrolled Licensed Vocational Nurse or Registered Nurse who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.
5. "Private Duty Nursing" means nursing services provided in a Medi-Cal beneficiary’s home by a registered nurse or a licensed practical nurse, under the direction of a beneficiary’s physician, to a Medi-Cal beneficiary who requires more individual and continuous care than is available from a visiting nurse
6. PartnershipHC is required to provide Case Management Services as set forth in its Medi-Cal contract to all plan enrolled Medi-Cal beneficiaries who are EPSDT eligible and for whom Medi-Cal Private Duty Nursing services have been approved, including, upon a plan member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the plan member, even when the PartnershipHC is not financially responsible for paying for the approved Private Duty Nursing services. Medi-Cal Private Duty Nursing services include Private Duty Nursing services approved under the California Children’s Services Program (CCS).
7. When PartnershipHC has approved a plan-enrolled EPSDT-eligible Medi-Cal beneficiary to receive Private Duty Nursing services, under either CCS or Medi-Cal, PartnershipHC has primary responsibility to provide Case Management for approved Private Duty Nursing services.
8. Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved Private Duty Nursing services, an EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal Private Duty Nursing services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be the Managed Care Plan, or the Home and Community Based Alternatives Waiver Agency) to request Case management for Private Duty Nursing services. The contacted Medi-Cal program entity must then provide Case Management Services as described herein to the beneficiary and work

collaboratively with the Medi-Cal program entity primarily responsible for Case Management.

9. Partnership~~HC~~ shall use one or more Home Health Agencies, Individual Nurse Providers, or any combination thereof, in providing Case Management Services as set forth in the Medi-Cal contract to plan enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services, including, upon that member's request, Case Management Services to arrange for all approved Private Duty Nursing services desired by the member, even when the Plan is not financially responsible for paying for the approved Private Duty Nursing services.
10. Partnership~~HC~~ members, their parents/caregivers and/or their representatives may contact Partnership~~HC~~ directly to request PDN services or support in obtaining PDN services.
11. Partnership~~HC~~'s obligations to plan enrolled EPSDT eligible Medi-Cal beneficiaries approved to receive Private Duty Nursing services who request Case Management Services for their approved Private Duty Nursing services include, but are not limited to:
    a. Providing the member information about the number of Private Duty Nursing hours that they are approved to receive
    b. Contacting enrolled Home Health Agencies and enrolled and Individual Nurse Providers to seek approved Private Duty Nursing services on the member's behalf
    c. Identifying and assisting potentially eligible Home Health Agencies and Individual Nurse Providers with navigating the process or navigating to become a Medi-Cal provider
    d. Working with Home Health Agencies and enrolled Individual Nurse Providers to jointly provide Private Duty Nursing services to the member as needed.
    e. Documentation of the member/parent/caregiver's request for case management assistance and all efforts to locate, collaborate with providers for PDN services
    f. If applicable, documentation of the member/parent/caregiver's decline of case management assistance, including the member's desire to not utilize all of the approved PDN hours.

VII. REFERENCES:

A. Title 42 United States Code (USC) Sections 1396, 1396d(a) and (r), 1396s(c)(2)(B)(i)
B. Title 42 Code of Federal Regulations (CFR) Sections 441.18 and 440.169
C. Title 22 California Code of Regulation (CCR) Sections 51184(d), (g)(5) and (h); 51340(e)
D. Health and Safety Code sections 1727(a) and (b)
E. Welfare and Institutions Code (WIC) Section 14132(v)
F. Mental Health Parity and Addiction Equity Act
G. Social Security Act Section 1905(r)
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
I. DHCS APL 20-012: Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age of 21 (05/15/2020).
J. DHCS APL 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)

VIII. DISTRIBUTION:

A. Partnership~~HC~~ Department Directors
B. Partnership~~HC~~ Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 10/14/20; 02/10/21; 02/09/22; 02/08/23; 02/14/24; 02/12/25

PREVIOUSLY APPLIED TO:

Policy/Procedure Number: MCCP2031			**Lead Department: Health Services** Business Unit: Care Coordination
Policy/Procedure Title: Private Duty Nursing under EPSDT			☒ **External Policy** ☐ **Internal Policy**
Original Date: 09/09/2020		**Next Review Date: 02/12/2026** **Last Review Date: 02/12/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	**Partnership Advantage**

Medi-Cal (CP100205; MCCP2005: 04/18/2001 to 02/13/2019 when Archived)
04/17/02; 08/20/03; 04/20/05; 01/18/06; 01/16/08; 09/19/12; 01/20/16; 09/21/16; 08/16/17 to 02/13/2019

Please reference MCCP2022 for coverage of services between 02/13/2019 and 09/09/2020

Medi-Cal (UP100365; MCUP3065; MCCP2022) 03/16/2005 to 09/09/2020)
08/16/17; *06/13/18; 02/13/19; 11/13/19; 02/12/20; 09/09/20

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PartnershipHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PartnershipHC.

PartnershipHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPCP2017 (previously MPQP1024, MPQG1024, QG100124)</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/18/2004 (QG100124)</td><td colspan="4">Next Review Date: ~~02/14/2025~~02/12/2026
Last Review Date: ~~02/14/2024~~02/12/2025</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 2/12/2025~~02/14/2024~~</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3101 - Screening and Treatment for Substance Use Disorders
B. MCQG1005 - Adult Preventive Health Guidelines
C. MCUP3028 - Mental Health Services
D. MPUP3126 - Behavioral Health Treatment (BHT) for Members Under the Age of 21

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Non-Specialty Mental Health Services (NSMHS): *aka Mild to Moderate Mental Health Services*
Managed Care Plans (MCPs) are required to provide or arrange for provision of the following NSMHS:
1. Mental health evaluation and treatment, including individual, group and family psychotherapy
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
3. Outpatient services for the purposes of monitoring drug therapy
4. Psychiatric consultation
5. Outpatient laboratory, medications[1], supplies, and supplements

B. Specialty Mental Health Services (SMHS) *aka Serious and Persistent Mental Health Services* are those provided by County Mental Health Plans, generally for members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice ~~-~~(BHIN) 21-073.

IV. ATTACHMENTS:

A. Carelon/ Partnership~~HC~~ Behavioral Health Care Management Referral Form (including Authorization for Carelon Behavioral Health, Inc. to Release Confidential Information)
B. Carelon/ Partnership~~HC~~ Primary Care Provider (PCP) Referral Form (including Authorization for Carelon Behavioral Health, Inc. to Release Confidential Information)

[1] As per APL 22-012 *Revised*, this does not include medications covered by Medi-Cal Rx: *https://medi-calrx.dhcs.ca.gov/home/education/*

Policy/Procedure Number: MPCP2017 (previously MPQP1024, MPQG1024, QG100124)			**Lead Department: Health Services** Business Unit: Care Coordination
Policy/Procedure Title: Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines			☒**External Policy** ☐**Internal Policy**
Original Date: 02/18/2004 (QG100124)		**Next Review Date: ~~02/14/2025~~02/12/2026** **Last Review Date: ~~02/14/2024~~02/12/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒**Partnership Advantage**

V. PURPOSE:

The purpose of this guideline is to 1) Define the scope of primary care practice regarding behavioral health and/or substance use disorder conditions and 2) To define appropriate situations for referral for ~~mild to moderate behavioral health conditions~~Non-Specialty Mental Health Services (NSMHS) to Partnership HealthPlan of California's ~~(PHC's)~~ delegated managed behavioral health organization, Carelon Behavioral Health ~~(formerly known as Beacon Health Options)~~ (855) 765-9703, and for referral to County Mental Health Plans and/or County Substance Use Disorder Services as appropriate. The guideline is intended to facilitate communication between primary care providers (PCPs) and behavioral health specialists and to help identify educational opportunities for the Partnership ~~HealthPlan of California (PHC)~~ provider network.

VI. POLICY / PROCEDURE:

A. Partnership~~HC~~ utilizes this guideline to generally define the services and responsibilities of ~~Primary Care Providers (~~PCPs~~)~~ and behavioral health providers. PCPs are responsible for all services within the scope of primary care required by the patient except when clinical circumstances preclude the PCP role. The PCP's services are personal, and their responsibility is continuous. The scope of the responsibility is comprehensive, (i.e., all required services including preventive services). The PCP should provide those services which can be provided within their competence and should obtain consultation when additional knowledge or skills are required. Partnership~~HC~~ recognizes that differences in skill level exist among PCPs; this document serves as a general guideline to define the scope of services and the indications for specialty referrals. PCPs should continue to use their sound clinical judgment when considering the need for specialty evaluation. Consultation includes advice received from a specialist and the referral of a patient to a specialist for services. When care by specialists is required, it is the responsibility of the PCP and the specialists to coordinate all services.

B. The PCP should be responsible for providing the following in regards to basic behavioral health conditions:
   1. Obtain developmental and psychosocial histories and perform mental status examinations when indicated by psychiatric or somatic presentations.
   2. Routinely screen for common behavioral health and substance use disorder conditions.
      a. The plan has adopted, and Partnership~~HC~~ contracted providers are expected to follow, the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services. Routine screening for depression is recommended by the USPSTF. Please refer to Partnership~~HC~~'s Adult Preventive Health Guidelines policy MPQG1005 for further details.
      b. Additionally, current versions of behavioral health and substance use disorder screening forms may be found on the Carelon Behavioral Health (formerly known as Beacon) website at this address: https://www.carelonbehavioralhealth.com/providers/resources/provider-toolkit
      c. Screening for alcohol misuse is also required. Please refer to policy MCUP3101 Screening and Treatment for Substance Use Disorders for details.
   3. Ascertain whether individuals are experiencing symptoms that would warrant emergent or urgent psychiatric evaluation, such as significant suicidal or homicidal ideation and/or grave disability as defined by the Lanterman-Petris-Short Act (LPS) (see this web page: https://ajud.assembly.ca.gov/sites/ajud.assembly.ca.gov/files/Kim%20Lewis%2C%20National%20Health%20Law%20Program%20slides.pdf), active substance intoxication/withdrawal/use disorder, or disorganized thinking or psychomotoric agitation, and making appropriate referrals to complete these evaluations as clinically indicated.
   4. Evaluate and provide ongoing management for the following:
      a. Psychiatric factors affecting a medical condition and psychiatric symptoms precipitated by medications being used to treat medical conditions
      b. Personality disorders that meet (or do not meet) the full criteria for a Diagnostic and Statistical Manual (DSM) diagnosis and the severity of which does not necessitate SMHS.

c. Medical assessments of members to evaluate and treat general medical conditions causing or exacerbating psychiatric symptoms.
d. Initial diagnosis and treatment of dementia. Differentiate dementia from other disorders effecting cognition, such as delirium, schizophrenia, substance misuse, and depression. Manage general medical factors that improve or worsen dementia. (See policy MCQG1005 - Adult Preventive Health Guidelines for more information on cognitive health assessments for members who are 65 years of age or older)

C. The PCP should be responsible for the initial evaluation and referral for behavioral health services as follows:
1. Medi-Cal only Members (with no Medicare):
a. All mental health services for these members are provided either by Carelon Behavioral Health's network of providers for Non-Specialty Mental Health Services (mild to moderate behavioral health conditions) or by County Mental Health Plans for Specialty Mental Health services (aka serious and persistent mental health services).
b. Substance use disorder and substance misuse services for members in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano counties are provided by Partnership HealthPlan. Substance use disorder and substance misuse services for members in other counties are provided by County Substance Use Programs. In all counties, substance use disorder and substance misuse treatment services may also be provided within the Partnership~~HC~~ network through Medications for Addiction~~Assisted~~ Treatment (MAT); see policy MCUP3101 Screening and Treatment for Substance Use Disorders for further information.
2. PCP may determine a diagnosis or provisional diagnosis for the following behavioral health conditions: schizophrenia/psychotic disorder, bipolar depression, depression, anxiety disorder, impulse control disorder, adjustment disorder, personality disorder (except anti-social), eating disorder, pervasive developmental disorder, disruptive behavior/attention deficit disorder, feeding and eating/elimination disorders, other disorders of infancy, childhood, or adolescence, somatoform disorders, factitious disorders, dissociative disorders, paraphilias, gender dysphoria, substance-related and addictive disorders.
3. PCP should determine the level of functional impairment in the following life domains resulting from the behavioral health condition:
a. Independent living skills
b. Social relations
c. Physical condition (chronic medical condition)
d. Vocational/ Employment
e. Sexual Functioning
f. Self-care
g. Decision making
h. Legal
i. Residential instability
4. PCP should assess risk factors linked to the further deterioration of behavioral health conditions such as:
a. Psychiatric hospitalization
b. Criminal behaviors and criminal justice system involvement
c. Suicidal/homicidal ideations and behavior
d. Experiencing psychotic or mood symptoms (especially in youth and transitional aged youth)
e. Self-injurious behavior (especially that which required medical attention)
f. Sexual aggression with risk of re-offending
g. Inability to adequately self-care

h. Ongoing substance misuse

5. For mental health conditions, PCP should refer Medi-Cal ~~-~~only members to Carelon Behavioral Health when a provisional diagnosis is present or the diagnosis is uncertain, where functional impairment is considered to be in mild to moderate range, and where there are no deterioration/risk factors.
   a. When Member's needs are outside PCP scope, PCP may refer for Outpatient Behavioral Health Services for therapy or medication management via Carelon's network of providers by providing the member with the Carelon Behavioral Health referral number (855) 765-9703. PCP can also fax a Carelon/Partnership~~HC~~ PCP Referral Form (Attachment B) to Carelon at fax: (877) 321-1787 or use secure email to: medi-cal.referral@carelon.com. Licensed Mental Health Providers at Carelon will utilize DHCS Screening and Transition of Care Tools as per footnote 3 in APL 22-028 to determine the appropriate mental health delivery system referral, including coordination with county MHP if necessary (see policy MCUP3028 Mental Health Services for more information).
   b. PCP may request PCP Decision Support, which allows consultative peer discussion related to member diagnostic and medication clarification; the PCP may request a telephone consultation with a Carelon psychiatrist using the Carelon/ Partnership~~HC~~ PCP Referral Form (Attachment B). Before phone consult with Carelon, PCP should fax medication list and last 2 PCP progress notes for Psychiatrist review. Fax: (877) 321-1787 or secure email: ~~-~~medi-cal.referral@carelon.com
   c. PCP may refer for Local Care Management to help link members to mental health providers, support their transition between levels of care, or engage members with history of non-compliance and link them to community services by sending the Carelon/Partnership~~HC~~ Behavioral Health Care Management Referral Form (Attachment A) to Carelon Fax: (855) 371-2279 or email: MediCal_PHP@carelon.com
   d. Primary care sites with integrated behavioral health, whose mental health professionals are credentialed with Carelon, may co-manage patients who would qualify for the ~~"mild to moderate"~~NSMHS mental health benefit.
   e. After initial evaluation and/or referral, the PCP may continue to follow and treat a Partnership~~HC~~ member based on their current clinical competence and in collaboration with the behavioral health specialist as appropriate.
6. PCP should refer members to County Mental Health Plans when a provisional diagnosis is present and when functional impairment is considered to be in the SMHS (moderate to severe) range, and/or when any risk factor is present.
   a. The process of accessing mental health services in each county may be different. For initial telephone contacts, PCPs can refer to this webpage for County Mental Health contact information: http://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Mental-Health-Services.aspx.
   b. Patients with emergency psychiatric conditions should be referred for emergency evaluation, calling the county-designated crisis phone number to arrange for services: https://www.partnershiphp.org/Providers/BehavioralHealth/Documents/CrisisLines_Final_MH.pdf.~~https://www.partnershiphp.org/Providers/BehavioralHealth/Documents/Crisis%20Lines.pdf~~
   c. After initial evaluation and/or referral, the PCP may continue to follow and treat a Partnership~~HC~~ member based on ~~his/her~~their current clinical competence and in collaboration with the behavioral health specialist, as appropriate.
   d. Federally Qqualified H~~h~~ealth C~~c~~enters (FQHCs) with integrated mental health may provide outpatient services for patients who would otherwise qualify for County Specialty Mental Health Services. These services are billed directly to the S~~s~~tate.
7. PCP should screen and refer Medi-Cal ~~-~~only Members with substance use disorders and misuse as

follows:

a. Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) should be performed by PCP.
b. The process of accessing substance use disorder services in each county may be different.
   1) For Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano counties, members should be referred to Carelon Behavioral Health (855) 765-9703 for call center assistance to identify substance use disorder service~~s~~ providers.
   2) In all other counties, the first point of telephone contact for substance use disorder referrals for each county can be located on the Partnership~~HC~~ website on this webpage under the heading "Alcohol and Drug Treatment ~~(Substance Use Services)~~": http://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx
c. For details on substance use disorder and alcohol misuse screening and referral, see policy MCUP3101 Screening and Treatment for Substance Use Disorders.
d. Provide ongoing follow-up as jointly determined by the PCP and Substance Use Disorder treatment provider for members whose substance use disorder conditions have reached a high degree of stability.

8. Psychiatric manifestations of neurologic disorders, developmental neurologic disorders, traumatic brain injury, and cognitive impairment: A specialist in neuropsychiatry is ideally suited to assist with these cases. Providers can refer to Carelon Behavioral Health to refer members for this service. Providers may also request case management from Carelon to assist in establishing connections for these services using the Carelon/Partnership~~HC~~ Behavioral Health Care Management Referral Form (Attachment A).
9. Behavioral Health Treatment (BHT) for Medi-Cal ~~-~~only Members Under the Age of 21: BHT is covered by Partnership~~HC~~ for members under the age of 21 through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services benefit. A Treatment Authorization Request (TAR) is required. See policy MPUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21.
10. School ~~-~~aged children may also have some assessment and treatment covered through their schools. School-based mental health services include a broad range of services, settings, and strategies. These services may include academic counseling, brief interventions to address behavior problems, family counseling, suicide prevention, and assessment and referral to other systems. Further information is available through your county mental health department.

VII. REFERENCES:

A. Latest USPSTF Guide to Clinical Preventive Services
B. County specific Mental Health Plan Memoranda of Understandings (MOUs)
C. Welfare and Institutions Code Sections 14132.03 and 14189
D. Title 9 of the California Code of Regulations, Chapter 11
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/23)
   - Specialty Mental Health Services Memorandum of Understanding Template
   - Substance Use Disorder Treatment Services Memorandum of Understanding Template
   - Drug Medi-Cal State Plan Memorandum of Understanding Template
F. DHCS All Plan Letter (APL) 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. (10/11/2021)
G. DHCS All Plan Letter (APL) 22-028 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (12/27/2022)

Policy/Procedure Number: MPCP2017 (previously MPQP1024, MPQG1024, QG100124)			**Lead Department: Health Services** Business Unit: Care Coordination
Policy/Procedure Title: Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines			☒**External Policy** ☐**Internal Policy**
Original Date: 02/18/2004 (QG100124)		**Next Review Date: ~~02/14/2025~~02/12/2026** **Last Review Date: ~~02/14/2024~~02/12/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒**Partnership Advantage**

VIII. DISTRIBUTION:

A. Partnership~~HC~~ Provider Manual
B. Partnership~~HC~~ Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 02/14/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Medi-Cal - MPQP1024
Original Date: 02/18/2004
Revision dates: 05/18/05; 04/19/06; 04/18/07; 04/16/08; 03/18/09 11/17/10; 01/16/13; 02/19/14; 05/20/15

Healthy Kids - MPCP2017, MPQP1024 (Healthy Kids Program ended 12/01/2016)
Original Date: 04/18/2007
Revision dates: 04/16/08; 03/18/09 11/17/10; 01/16/13; 02/19/14; 05/20/15 to 12/01/2016

Partnership Advantage:
MPQG1024 – 04/18/2007 to 11/17/2010
MPQP1024 – 11/17/2010 to 01/01/2015

Healthy Families:
MPQP1024 - 11/17/10 to 03/01/2013

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

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- Evaluated and updated at least annually
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Partnership~~HC~~'s authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPCP2002 (previously CP100202 & KK CC401)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: California Children’s Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/25/1995 – 12/31/2018
Archived Effective: 01/01/2019 – 12/31/2023
Reinstated Effective Date: 01/01/2024 – 12/31/2024</td><td colspan="3">Next Review Date: ~~03/13/2025~~N/A
Last Review Date: 03/13/2024</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">~~Approval~~ Archived Date:
~~03/13/2024~~02/12/2025
Archived Effective: 01/01/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCCP2031 – Private Duty Nursing under EPSDT
B. MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
C. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children’s Services
D. MCUP3041 – Treatment Authorization Request (TAR) Review Process
E. MCCP2014 – Continuity of Care
F. MCCP2024 – Whole Child Model For California Children’s Services (CCS)
G. MPCD2013 – Care Coordination Program Description
H. MCCP2035 – Local Health Department (LHD) Coordination
I. MCCP2002 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
J. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
K. MCUP3039 – Direct Members

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. California Children’s Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled
C. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
D. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
E. Medical Home: The provider identified as the member’s medical home or primary care provider (PCP) is responsible for managing the member’s primary care needs
F. Medi-Cal Rx: The program title established by the State of California Department of Health Care Services (DHCS) for the new system of administering Medi-Cal pharmacy benefits through the fee-for-services (FFS) delivery system effective Jan. 1, 2022. Refer to All Plan Letter (APL) 22-012 *Revised* for more information.
G. Memorandum of Understanding (MOU): Where no reimbursement is to be made, PHC shall

negotiate in good faith an MOU for services provided by said agency. MOU shall describe the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated.

H. Direct Members: are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status may be based on the member's medical condition, prime insurance, demographics or administrative eligibility status. Direct Members do not require a Referral Authorization Form (RAF) to see a specialist.

I. Whole Child Model (WCM): A comprehensive program for the whole child encompassing care coordination in the areas of primary, specialty, and behavioral health for pediatric members insured by PHC in participating counties: Lake, Marin, Mendocino, Napa, Solano, Sonoma, Yolo, Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

Beginning January 1, 2024. the collaboration between the California Children's Services (CCS) program and the Partnership HealthPlan of California (PHC) is an adjunct to the county specific Memorandum of Understanding (MOUs). The counties included are Tehama, Plumas, Glenn, Butte, Colusa, Sutter, Yuba, Sierra, Nevada, and Placer. For the remaining counties within PHC's coverage, please refer to MCCP2024 – Whole Child Model For California Children's Services (CCS) for details.

VI. POLICY / PROCEDURE:

A. CCS Program Responsibilities:
   1. Provide consultation to PHC regarding CCS regulations, policies and guidelines concerning CCS procedures, benefits, and criteria for authorizations and medical eligibility.
   2. Determine eligibility of a PHC member for the CCS program.
   3. Develop and implement a case management plan based on the CCS guidelines for the CCS eligible condition(s).
   4. Authorize services for care related to the CCS eligible condition(s) and make available documentation of such authorization to PHC.

B. PHC Responsibilities:
   1. Provide consultation to CCS regarding PHC benefits and policies and post regular updates to the online PHC Provider Manual.
   2. Assure that PHC/CCS members are assigned Direct Member) status from date of CCS eligibility determination through the last month of CCS eligibility. CCS medical eligibility cannot be earlier than PHC's effective date. (Commercial coverage takes precedence over CCS as primary payor).
   3. Work collaboratively with CCS and member to establish a medical home based on the complexity of the member's condition.

C. Primary Care Provider Responsibility:
   1. The provider identified as the child's medical home is responsible for managing the child's primary care needs and coordinating the child's care for both the CCS eligible condition(s) and the non-CCS eligible condition(s).
   2. For CCS eligible condition(s), a Service Authorization Request (SAR) from CCS is required. It is the responsibility of the provider of service to obtain the authorization.
   3. CCS children, as Direct Members, do not require a Referral Authorization Form (RAF) to see a specialist, for either the CCS eligible condition(s) or the non-CCS eligible condition(s).
   4. For non-CCS eligible conditions, CCS children require a Treatment Authorization Request (TAR) for

services that are on PHC's TAR Requirement List (see PHC policy MCUP3041 Treatment Authorization Request (TAR) Review Process. It is the responsibility of the provider of service to obtain the authorization.

D. Inter-county CCS Authorizations:
   1. PHC works in collaboration with respective CCS offices and providers as needed to transition a child into and out of their county of residence to ensure care is coordinated and that there are no barriers to accessing care.
   2. PHC does not honor CCS authorizations from counties outside the PHC network. TARs must be submitted directly to PHC.

E. Continuity of Care (COC)
   1. For members transitioning to new Managed Care Plans (MCPs) on January 1, 2024, refer to policy MCCP2014 Continuity of Care (Medi-Cal) for more details on COC processing requests.

F. Care Coordination:
   1. PHC shall execute an MOU outlining respective responsibilities and obligations under CCS (see PHC policy MCCP2035 – Local Health Department (LHD) Coordination for details).
   2. PHC and CCS must coordinate with Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) to ensure members who are individuals with developmental disabilities receive all medically necessary covered services in accordance with APL 23-023, please refer to MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities for more details.
   3. PHC in collaboration with the county CCS program must ensure that members living in ICF/DD Homes have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), Transitional Care Services (TCS), care management programs, and Community Supports as appropriate in coordination with the Regional Center. Please refer to MPCD2013 Care Coordination Program Description for more details.
   4. Representative staff from PHC and CCS meet on a quarterly or as needed basis to collaborate and discuss coordination of services and benefits between the CCS program and PHC / Medi-Cal and review case specific issues when necessary.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
B. DHCS APL 23-029: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023)
   - Local Health Department Memorandum of Understanding Template
C. DHCS All Plan Letter 23-018: Managed Care Health Plan Transition Policy Guide (06/23/2023)
D. DHCS All Plan Letter 22-012 Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx (*Revised* 12/30/2022)
E. DHCS All Plan Letter 23-023 (Revised): Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023)

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

Policy/Procedure Number: MPCP2002 (previously MPCP2002, CP100202 & KK CC401)		**Lead Department: Health Services**
Policy/Procedure Title: California Children's Services		**☒External Policy** **☐Internal Policy**
Original Date: 04/25/1995	**Next Review Date: ~~03/13/2025~~N/A** **Last Review Date: 03/13/2024**	
Applies to:	**☒ Medi-Cal**	**☐ Employees**

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

POLICY REINSTATED 03/13/24 **as MPCP2002 Effective 01/01/2024 through 12/31/2024** for the following ten counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba
ARCHIVED Effective 12/31/2024 due to ten counties joining Whole Child Model Program 01/01/2025 *(see policy MCCP2024)*

PREVIOUSLY APPLIED TO:

Medi-Cal (10/13/1995 to 12/31/2018)
10/13/95; 10/10/97 [name change only]; 06/02/00; 11/27/00, 12/20/00, 08/15/01, 04/16/03; 04/20/05; 01/16/08; 09/16/09; 09/19/12; 05/21/14; 01/20/16; 09/21/16; 09/20/17; Reviewed 11/14/2018 for ARCHIVE Effective 01/01/2019 due to Whole Child Model Program (*see policy MCCP2024)*

Partnership*Advantage*:
MPCP2002 - 01/16/2008 to 01/01/2015

Healthy Kids - MPCP2002 (Healthy Kids program ended 12/01/2016)
01/16/08; 09/16/09; 09/19/12; 05/21/14; 01/20/16; 09/21/16 to 12/01/2016

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCCP2019 (previously MCUP3117)			**Lead Department: Health Services**	
Policy/Procedure Title: Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services			☒ **External Policy** ☐ **Internal Policy**	
Original Date: Approved by DHCS 04/11/2013, First Committee Review 08/20/2014 (MCUP3117)		**Next Review Date:** ~~10/09/2025~~02/12/2026 **Last Review Date:** ~~10/09/2024~~02/12/2025		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~10/09/2024~~02/12/2025	

I. RELATED POLICIES:

A. MCUP3012 – Discharge Planning (Non-capitated Members)
B. MCUP3039 – Direct Members
C. MCCP2007 – Complex Case Management
D. MCCP2023 – New Member Needs Assessment
E. MCCP2024 – Whole Child Model for California Children's Services (CCS)
F. MPCD2013 – Care Coordination Program Description
G. MCCP2032 - CalAIM Enhanced Care Management (ECM)
H. MCUP3143 - CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
~~I.~~ MCCP2014 – Continuity of Care (Medi-Cal)
~~J.~~I. ~~MPCP2002 - California Children's Services~~

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Complex Case Management (CCM): The process of applying evidence-based practices to individual members to assist them with the coordination of their care and promote their well-being.
B. Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
C. Health Care Guide (HCG): A non-clinical Care Coordination staff member who provides support and guidance to members, families, providers community agencies and the interdisciplinary care team to assist in coordination of benefits in a timely and cost-effective manner while connecting members to available internal and external resources.
D. Health Risk Assessment (HRA): An assessment form mailed to newly enrolled adult members (ages 21 and over) with corresponding Seniors and Persons with Disabilities (SPD) aid codes who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).
E. Individualized Care Plan (ICP): A member-focused care plan designed to optimize the member's health, function, and well-being.
F. Nurse Case Manager (NCM): A registered nurse in Care Coordination who works with the

multidisciplinary team in order to facilitate coordination of the comprehensive medical, behavioral, and psychosocial needs of the member while promoting quality and cost-effective outcomes.

G. Pediatric Health Risk Assessment (PHRA): An assessment form mailed to newly enrolled pediatric members (under age 21) with corresponding Seniors and Persons with Disabilities (SPD) aid codes and/or California Children's Services (CCS) identifiers who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).

H. Social Worker (SW)/Medical Social Worker (MSW): A social worker in Care Coordination who provides members and/or their families with the supports needed to cope with chronic, acute and/or terminal illnesses, often complicated by other social/environmental or historical factors.

IV. ATTACHMENTS:

A. HRA
B. PHRA
C. HRA Stratification Matrix
D. PHRA Stratification Matrix

V. PURPOSE:

This policy describes the process Partnership Health Plan of California (Partnership) will follow to assess new enrollees who are designated as Seniors and Persons with Disabilities (SPD) and/or California Children's Services (CCS) upon enrollment and at least annually thereafter. The purpose of the assessment is to identify those SPD/CCS members at high risk for adverse health outcomes and to initiate appropriate individualized care plans to reduce that risk and optimize health.

VI. POLICY / PROCEDURE:

A. Member Risk Stratification
Partnership considers all newly enrolled SPD/CCS members as higher risk and therefore they are comprehensively assessed via the Health Risk Assessment (HRA) or Pediatric Health Risk Assessment (PHRA) form to determine their current health risk.

B. HRA/PHRA Process
1. All newly enrolled members designated with an SPD aid code and/or CCS identifier are sent the HRA (Attachment A) or PHRA (Attachment B) via mail within 10 calendar days of enrollment into the plan.
2. The HRA/PHRA forms are reviewed by the Chief Medical Officer, the Health Educator, and by the Consumer or Family Advisory Committee prior to implementation by the health plan, as are any and all revisions to the HRA/PHRA.
3. All newly enrolled SPD/CCS members are contacted telephonically within 45 days of enrollment in order to encourage the member to return the HRA/PHRA.
4. All questions on the HRA/PHRA forms are sent to each SPD/CCS beneficiary according to age upon enrollment. In no instance are any questions in the HRA/PHRA forms sent to a subset of the SPD/CCS population.
5. For those HRA/PHRAs completed, the member's responses will be captured and evaluated as follows:
   a. Adult member responses will be captured and evaluated utilizing the HRA Stratification Matrix (Attachment C) for adult members. Adult members will be placed in low or high risk categories.
      1) Low Risk – members will benefit from basic case management; or
      2) High Risk – member requires complex case management through an individualized care plan (ICP) to prevent adverse health outcomes.

b. All pediatric members who complete a PHRA are treated as high risk according to policy MCCP2024 Whole Child Model for California Children's Services (CCS). ~~and MPCP2002 California Children's Services.~~

C. Care Coordination

1. Low Risk Members
   a. Adult members who are stratified as low risk based on their responses to the HRA will be contacted by a Health Care Guide (HCG) within 30 calendar days of the returned HRA.
   b. The role of the HCG is to identify barriers to care and safety and to carry out non-clinical interventions to eliminate those barriers. Examples include, but are not limited to:
      1) Work with the primary care provider and/or specialist's offices to coordinate appointments
      2) Contact durable medical equipment (DME) vendors to facilitate timely delivery of appropriate medical equipment
      3) Work with community-based organizations to assist member with access to psychosocial services
      4) Arrange transportation as appropriate
      5) Resolve any claims issues
      6) Provide support and encouragement to the member and caregiver
      7) Evaluate the member for need for additional case management services available through the health plan.
      8) Facilitate referrals for Long Term Support Services (LTSS) needs identified
   c. The HCG, Nurse Case Manager (NCM), and Social Worker (SW) work together. Any clinical issues will be the responsibility of a licensed clinician.
2. High Risk Members
   a. Adult Members stratified as high risk, as well as all pediatric members who complete a PHRA, will be contacted by a NCM or SW within 14 days of the returned HRA/PHRA, and the member will be offered enrollment into Complex Case Management (CCM) (see policy MCCP2007 Complex Case Management.) The NCM/SW collaborates with a member's interdisciplinary care team and is responsible for the development of the individualized care plan (ICP) for a member stratified as high risk. They are also responsible for providing education and clinical support, facilitating appropriate communication among the interdisciplinary care team, and working closely with outside agencies and available community resources.
   b. The NCM/SW will discuss the HRA/PHRA results with the member and develop an ICP with interventions tailored to the particular needs of the member. The care plan will include, but is not limited to, needs such as:
      1) The member's identified medical care needs
      2) Access to primary and/or specialty care
      3) DME and/or medications
      4) Assessment of member's current use of community resources as well as provision of referrals to appropriate resources and/or services outside of the Plan's benefits (i.e. mental health and behavioral health services, personal care, housing, meal delivery programs, energy assistance programs and services for individuals with intellectual and developmental disabilities)
      5) Identification of the member's caregiver(s) and need for their involvement in the care plan
      6) Identification of an action plan to assist the member with other activities or services needed to optimize their health status, including:
         a) Process/Plan for coordination of care across all settings, including those outside the provider network

b) Process/Plan for referrals to resolve any physical or cognitive barriers to access care
c) Process/Plan for helping to facilitate communication among the member's health care providers
d) Process/Plan for identifying a member's need for other activities/services that would optimize their health status (e.g. self-management skills, health education classes, etc.)
e) For the member in a facility, a plan to ensure discharge planning and coordination is implemented
f) Designated date of follow-up and reassessment as often as necessary, but not less than annually
g) Referrals to LTSS services where applicable

c. For adult and pediatric members stratified as high risk, Partnership shall offer the CalAIM Enhanced Care Management (ECM) benefit for eligible members. The ECM benefit is unique and distinct from the care management services or programs offered by Partnership. Refer to policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) for more details.

D. Assessment and Reassessment
1. Populations required to receive an assessment as referenced in the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024 "Population Health Management Policy Guide" (11/28/2022) and the latest version of the DHCS CalAIM: Population Health Management (PHM) Policy Guide include:
a. Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver)
b. Those entering CCM, refer to policy MCCP2007 Complex Case Management.
c. Those entering ECM, refer to policy MCCP2032 CalAIM Enhanced Care Management (ECM)
d. Children with Special Health Care Needs (CSHCN)
e. Pregnant Individuals
f. Seniors and persons with disabilities who meet the definition of "high risk" as established in existing APL requirements, namely:
1) Members who have been authorized to receive:
a) IHSS greater than, or equal to, 195 hours per month;
b) Community-Based Adult Services (CBAS), and/or
c) Multipurpose Senior Services Program (MSSP) Services
2) Members who:
a) Have been on oxygen within the past 90 days;
b) Are residing in an acute hospital setting;
c) Have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year;
d) Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);
e) Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
f) Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;

g) Have cancer and are currently being treated;
h) Are pregnant;
i) Have been prescribed antipsychotic medication within the past 90 days;
j) Have been prescribed 15 or more prescriptions in the past 90 days;
k) Have a self-report of a deteriorating condition; and
l) Have other conditions as determined by the Partnership, based on local resources.

2. Each month, Partnership leverages age-based algorithms to capture emerging risk in the entire population including, but not limited to SPD or CCS members, to promote timely reassessment for members whose risk level demonstrates need for intervention.
   a. The Monthly Utilization Report analyzes claims data and other predictive modeling factors for members based upon age – adults (ages 21 and over) and pediatrics (under age 21).
   b. Any member who shows as high risk on one of these reports will be contacted by Partnership Care Coordination staff for telephonic reassessment, unless the member is currently enrolled in care coordination. Members recently closed to care coordination will be reassessed if their case was closed more than 30 calendar days prior to new risk identification for pediatric members, and 90 days prior to new risk identification for adult members.
   c. In addition, if the Monthly Utilization Report reveals a potential CCS condition in a pediatric member, that case will be referred to the CCS County program for CCS eligibility determination according to policy MCCP2024 -Whole Child Model for California Children's Services (CCS). ~~and MPCP2002 California Children's Services.~~

E. Extended Continuity of Care (COC)
   1. Newly enrolled SPD/CCS members who request continued access to a provider who is not part of Partnership's network will be permitted to remain with that provider for up to 12 months as long as certain criteria are met. Partnership will begin processing requests for extended COC and will follow the COC process as described in policy MCCP2014 Continuity of Care (Medi-Cal).

F. Diversity Equity and Inclusion Training
   1. Partnership provides Partnership-developed sensitivity, diversity, cultural competency and cultural humility, and health equity trainings to Partnership staff; providers and provider staff, and delegated entities and delegate's staff.
   2. Partnership also provides the training to each aforementioned party who serves seniors and individuals living with disabilities. This training is done via webinar.
   3. Documentation of trainings is maintained and is available upon request.

VII. REFERENCES:

A. Welfare and Institutions Code Section 14182
B. DHCS All Plan Letter 22-024: Population Health Management Program Guide (11/28/2022)
C. DHCS CalAIM: Population Health Management (PHM) Policy Guide (May 2024) https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf
D. DHCS All Plan Letter 24-015~~3-034~~: California Children's Services Whole Child Model Program (12/02~~27~~/2024~~3~~)
E. DHCS All Plan Letter 23-025: Diversity, Equity, and Inclusion Training Program Requirements (09/14/2023)
F. DHCS Medi-Cal Managed Care Plans Mandatory or Voluntary Enrollment by Medi-Cal Aid Codes 2022-2023

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

MCCP2019 (effective 02/15/17)
10/18/17; *11/14/18; 11/13/19; 09/09/20, 09/08/21; 10/12/22; 11/08/23; 10/09/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

MCUP3117 (04/11/2013 to 02/15/2017)
05/20/15; 04/20/16 to 02/15/17

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCCP2022 (previously MCUP3065; UP100365)			**Lead Department: Health Services**	
Policy/Procedure Title: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services			☒**External Policy** ☐ **Internal Policy**	
Original Date: 03/16/2005 (MCUP3065)		**Next Review Date:** ~~09/11/2025~~02/12/2026 **Last Review Date:** ~~09/11/2024~~02/12/2025		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** 02/12/2025~~09/11/2024~~	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
C. MPUP3126 – Behavioral Health Therapy (BHT) for Members Under the Age of 21
D. MCCP2016 – Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
E. MCQG1015 – Pediatric Preventive Health Guidelines
F. MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
G. MPUP3048 – Dental Services (including Dental Anesthesia)
H. MCUG3019 – Hearing Aid Guidelines
I. MCCP2031 – Private Duty Nursing Under EPSDT
J. MCUP3028 – Mental Health Services
~~K.~~ MCND9002 – Cultural & Linguistic Program Description
~~L.~~K. ~~MPCP2002 – California Children's Services~~
~~M.~~L. MCCP2035 – Local Health Department (LHD) Coordination
~~N.~~M. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
~~O.~~N. MCUP3102 - Vision Care

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Ameliorate: To make more tolerable or to make better
B. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
C. DHCS: Department of Health Care Services
D. EPSDT: Early and Periodic Screening, Diagnostic, and Treatment (*see also Medi-Cal for Kids and Teens below*)
E. FFS: Fee-for-Service
F. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled
G. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative

H. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
I. LEA: Local Education Agency
J. Maintenance Services: Services that sustain or support rather than cure or improve health problems
K. Medi-Cal for Kids and Teens: DHCS refers to EPSDT as "Medi-Cal for Kids and Teens" in outreach and education materials. DHCS has developed child-focused and teen-focused brochures that provide an overview of EPSDT, including Covered Services, how to access those services, and the importance of Preventive Care and also a "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter that illustrates what to do if Medi-Cal care is denied, delayed, reduced, or stopped, including who to contact, how to file grievances and appeals, and how to access other enrollee assistance resources.
L. Medical Necessity for EPSDT Services: For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services
M. NCHCC: Northern California Hearing Coordination Center
N. Newborn Hearing Screening Program (NHSP): DHCS has implemented this statewide comprehensive program that helps identify hearing loss in infants and guide families to the appropriate services needed to develop communication skills.
O. TCM: Targeted Case Management
P. Whole Child Model (WCM): ~~In participating counties, T~~this program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for any Partnership HealthPlan of California (Partnership) pediatric members with a CCS-eligible condition(s).

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define Partnership HealthPlan of California's (Partnership's) responsibility to cover medically necessary services not covered under the Medi-Cal Program for individuals under the age of 21 under the Early and Periodic Screening Diagnostic, and Treatment (EPSDT) supplemental services benefit, also referred to as "Medi-Cal for Kids and Teens."

VI. POLICY / PROCEDURE:

A. Partnership covers and ensures the provision of screenings and preventive and medically necessary diagnostic and treatment services for members under the age of 21 in accordance with the EPDST program benefit.
B. Partnership provides information regarding EPSDT services for members which can be found in the Partnership Medi-Cal Member Handbook and in the "Medi-Cal for Kids and Teens" letter and education materials provided by DHCS and available on their website: https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Resources.aspx . In addition, Partnership annually provides information to all members, their families and/or caregivers about available EPSDT services through Partnership's website at http://www.partnershiphp.org/ and also through Member Newsletters which are mailed twice a year (summer and winter) and can also be accessed from this Partnership webpage: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Member-Newsletter.aspx .
    1. Partnership provides member information in accordance with all language and accessibility standards as described in Partnership policy MCND9002 Cultural & Linguistic Program Description.
C. Section 1905(r) of the Social Security Act (SSA) defines the EPSDT benefit to include a comprehensive array of preventative, diagnostic, and treatment services for low-income individuals under the age of 21.

Title 42 of the United States Code (USC), Section 1396d(r), defines EPSDT services to include the following:

1. Early and Periodic Screening, Diagnostic and Treatment services: These are services that are provided at intervals, which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and at such other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. Screening services, at a minimum must include a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed exam; appropriate immunizations (according to Title 42 of USC Section 1396s(c)(2)(B)(i) for pediatric vaccines for age and health history); laboratory tests (including blood lead level assessment appropriate for age and risk factors); and health education (including anticipatory guidance).
2. Vision services provided at intervals, which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Vision services must include, at a minimum, diagnosis and treatment for defects in vision, including eyeglasses. For more information, see Partnership policy MCUP3102 Vision Care.
3. Dental services provided at intervals, which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Dental services must include, at a minimum, treatment of relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services are carved out to the State, with the exception of medically necessary dental anesthesia.
4. Hearing services provided at intervals, which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids. For more information, see Partnership policy MCUG3019 Hearing Aid Guidelines.
5. Other necessary health care, diagnostic services, treatment and other measures as described in 42 USC 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.
6. Partnership ensures that members have timely access to all medically necessary EPSDT services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventative screening or other visit that identifies a need for follow-up.

D. The EPSDT benefit in California is established in the Medi-Cal Schedule of Benefits set forth in Welfare and Institutions Code (WIC) Section 14132(v), which states that "Early and periodic screening, diagnosis and treatment for any individual under the age of 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code."

E. For members under the age of 21, Partnership will provide the EPSDT benefit in accordance with the AAP/Bright Futures periodicity schedule. For more information, see Partnership policy MCQG1015 - Pediatric Preventive Health Guidelines.

F. For members under the age of 21, Partnership will provide and cover all medically necessary EPSDT service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of Partnership's contract, regardless of whether such services are covered under California's

Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

G. An EPSDT service need not cure a condition in order to be covered. Services that maintain or improve the child's current health condition are also covered under EPSDT because they 'ameliorate' a condition. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.

H. Additional services must be provided if determined to be medically necessary for an individual child (as per III.L above). Medical necessity determinations for services requested under EPSDT are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements and are not permitted. Requests are reviewed on a case-by-case basis and take into account the particular needs of the member:
   1. Children with mild to moderate mental health issues or conditions are the responsibility of Partnership and services for them are available through Carelon Behavioral Health (formerly known as Beacon Health Options) as Partnership's subcontractor.
   2. The supplies, items or equipment to be provided are medical in nature.
   3. The services are not requested solely for the convenience of the member, family, physician or other provider of service(s).
   4. The services are not unsafe for the individual, and are not experimental.
   5. The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the member's appearance. The correction of severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the member's appearance.
   6. Where alternative medically accepted modes of treatment are available, the services are the most cost-effective.

I. EPSDT services must meet all of the following criteria:
   1. Must be generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence consisting of well-designed and well-conducted investigations published in peer-review journals and have opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can screen, diagnose, correct or ameliorate the conditions for which they are prescribed.
   2. Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the health condition of the member.
   3. The predicted beneficial outcome of the services outweighs the potential harmful effects.
   4. Available scientific evidence demonstrates that the services improve the overall health outcomes as much as, or more than, established alternatives.
   5. The total cost of providing services and all other medically necessary Medi-Cal services to the beneficiary is not greater than the costs incurred in providing medically necessary equivalent services at the appropriate institutional level of care as outlined by State and Federal law.

J. Upon adequate evidence that a member has a California Children's Services (CCS) eligible condition, Partnership will refer the member to the local county CCS office for determination of CCS program eligibility. If the local CCS program does not approve eligibility, Partnership remains responsible for the provision of all medically necessary covered services for the member. For more information, see Partnership policy MCCP2024 Whole Child Model for California Children's Services (CCS). ~~For non-WCM counties, refer to Partnership policy MPCP2002 California Children's Services.~~

K. Partnership is responsible for providing medically necessary Behavioral Health Treatment (BHT) under EPSDT. For more information, see Partnership policy MPUP3126 Behavioral Health Therapy (BHT) for Members Under the Age of 21.

L. Partnership has the primary responsibility to provide medically necessary EPSDT services, including

services which exceed the amount provided by Local Education Agency (LEA) programs, Regional Centers (RCs), CCS, or local governmental health programs, and will not rely on these or other entities as the primary provider. Where another entity, such as an LEA, RC, or local governmental health program has overlapping responsibility for providing services to a member under the age of 21, Partnership will:

1. Assess what level of EPSDT medically necessary services the member requires
2. Determine what level of service (if any) is being provided by the other entities, and
3. Coordinate the provision of services with the other entities to ensure that Partnership and the other entities are not providing duplicative services, and that the member is receiving all medically necessary services in a timely manner.

M. Targeted Case Management (TCM)

The EPSDT benefit includes case management and care coordination for all medically necessary EPSDT services. Partnership ensures the coverage of TCM services designed to assist the member in gaining access to necessary medical, social and educational and other services. When the need for TCM services is identified, Partnership shall:

1. Determine whether a member requires Case Management (CM) or Targeted Case Management (TCM) services under EPSDT.
2. For members who are eligible for CM or TCM services, Partnership will either provide services or refer and collaborate with the appropriate agency, RC or local government health program where applicable.
3. If a member is currently receiving TCM services, Partnership will coordinate the member's health care needs and EPSDT services with the TCM provider.
4. If Partnership determines that an eligible member is not accepted for TCM services, Partnership will ensure that the member has access to services comparable to EPSDT TCM services.

N. Transportation

1. Under the EPSDT benefit, for members under the age of 21, Partnership:
   a. May provide medical (NEMT) and non-medical (NMT) transportation, meals and/or lodging to and from any medically necessary covered EPSDT appointment as outlined by Title 42 Code of Federal Regulations (CFR) Section 440.17 (a)(3).
   b. Shall provide appointment scheduling assistance to and from medical appointments for the medically necessary EPSDT services covered by Partnership.
2. For more information, see Partnership policy MCCP2016 Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT).

O. Dental Services

1. Most dental services are carved-out of Partnership's contract with DHCS. Under EPSDT, for member under the age of 21 Partnership will:
   a. Cover and ensure that dental screenings/oral health assessments for all members are included as part of the initial health assessment.
   b. Ensure providers perform a dental screening/oral health assessment as part of every periodic assessment
   c. Encourage providers to make annual dental referrals no later than 12 months of age or when referral is indicated.
   d. Cover and ensure that fluoride varnish and oral fluoride supplementation assessment and provision is consistent with AAP/Bright Futures periodicity schedule and anticipatory guidance.
   e. Cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists.
   f. Ensure that providers refer members to appropriate Medi-Cal dental providers.
2. For more information, see Partnership policy MPUP3048 Dental Services (including Dental Anesthesia).

P. Excluded Services
For members under the age of 21, Partnership is required to cover all medically necessary EPSDT services except those services that are specifically carved out of Partnership's contract with DHCS. Carved-out services vary and can include, but are not limited to, dental services, specialty mental health services, non-medical services provided by the Regional Center(s), etc. In addition, Partnership does not reimburse families or caregivers for care.

Q. For services to be considered under the EPSDT benefit, a Treatment Authorization Request (TAR) must be accompanied by the following information:
1. The principal diagnosis and significant associated diagnoses
2. Prognosis
3. Date of onset of the illness or condition; and etiology if known
4. Clinical significance or functional impairment caused by the illness or condition
5. Specific types of services to be rendered by each discipline, and anticipated time for achievement of the goals
6. The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care
7. Any other documentation available that may assist Partnership in making determinations related to medical necessity.

R. Newborn Hearing Screening Program (NHSP)
1. Partnership is responsible for case management services related to EPSDT and collaborates with the PCP and/or Specialist to ensure follow-up for missed EPSDT-related appointments, which includes follow-up with the families of babies that miss their hearing screening or diagnostic appointments. Partnership's Care Coordination department will receive referrals from the Northern California Hearing Coordination Center (NCHCC) to assist in case management services for access to care concerns and following up on missed hearing screening or diagnostic appointments.
2. Partnership providers can refer members who have missed or failed EPSDT-related appointments through the external referral form on the Partnership's website. Our Care Coordination staff may also reach out to the member once the referral is received to assist with care coordination services and identify barriers.

S. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N)
1. For more information, refer to Partnership policy MPCP2006 Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities and MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities.

VII. REFERENCES:

A. Title 42 United States Code (USC) Sections 1396, 1396d(a) and (r), 1396s(c)(2)(B)(i)
B. Title 22 California Code of Regulation (CCR) Section51340(e)
C. Title 9, California Code of Regulation (CCR), Section 1810.247, 1820.205, 1830.210
D. Welfare and Institutions Code (WIC) Section 14132(v)
E. Mental Health Parity and Addiction Equity Act
F. Social Security Act Section 1905 (a) and (r)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
H. DHCS webpage with resources for "Medi-Cal for Kids and Teens": https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Resources.aspx
I. DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities --

Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023)

VIII. DISTRIBUTION:
A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:
MCCP2022 - (as of 02/15/17)
08/16/17; *06/13/18; 02/13/19; 11/13/19; 02/12/20; 09/09/20; 09/08/21; 10/12/22; 10/11/23; 02/14/24; 06/12/24; 09/11/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
MCUP3065 (03/16/2005 to 02/15/2017)
10/18/06; 07/15/09; 01/18/12; 02/18/15; 02/17/16 to 02/15/2017

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCCP2023</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: New Member Needs Assessment</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 08/16/2017</td><td colspan="4">Next Review Date: ~~10/09/2025~~02/12/2026
Last Review Date: ~~10/09/2024~~02/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td></td><td colspan="3">☐ Employees</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 02/12/2025~~10/09/2024~~</td></tr>
</table>

I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description

B. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services

~~C.~~ MCCP2024 – Whole Child Model for California Children's Services (CCS)

~~D.~~C. ~~MPCP2002 - California Children's Services~~

II. IMPACTED DEPTS:

A. Health Services

B. Information Technology

C. Member Services

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.

B. Care Coordination (CC) Staff: Partnership's CC staff members have either experience in health care fields (e.g., Medical Assistant, Emergency Medical Technician, etc.) or are licensed and possess the appropriate skills and training to assist members. All staff are trained in care coordination and motivational interviewing.

C. Health Information Form (HIF)/Member Evaluation Tool (MET): Screening tool sent to newly enrolled members to identify members needing expedited care.

D. Health Risk Assessment (HRA): An assessment form mailed to newly enrolled adult members (ages 21 and over) with corresponding Seniors and Persons with Disabilities (SPD) aid codes who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).

E. Pediatric Health Risk Assessment (PHRA): An assessment form mailed to newly enrolled pediatric members (under age 21) with corresponding Seniors and Persons with Disabilities (SPD) aid codes and/or California Children's Services (CCS) identifiers who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).

F. Whole Child Model (WCM): ~~In participating counties, T~~this program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for any Partnership HealthPlan of California (Partnership) pediatric members with a CCS-eligible condition(s).

IV. ATTACHMENTS:

A. HIF Form

B. HRA Form

C. PHRA Form

V. PURPOSE:

This policy describes the process Partnership HealthPlan of California (Partnership) will follow to assess new plan enrollees in order to identify those members who may need expedited services.

VI. POLICY / PROCEDURE:

A. New Member Outreach Process

1. All newly enrolled members designated with an SPD aid code and/or CCS identifier are sent the HRA (Attachment B) or PHRA (Attachment C) via mail within 10 calendar days of enrollment into the plan along with a postage-paid envelope for response. The HRA includes both questions from the HIF tool as well as additional questions appropriate for assessing the need for expedited services for high-risk members. (See policy MCCP2019 for the full process of screening of Seniors and Persons with Disabilities and/or California Children's Services beneficiaries, and risk assignment process.)
2. For more information on the assessment, outreach and case management activities for CCS members, please see Partnership policy MCCP2024 Whole Child Model for California Children's Services. ~~and MPCP2002 California Children's Services.~~
3. All newly enrolled members who are designated with neither an SPD aid code nor a CCS identifier are sent the HIF/MET form (Attachment A) via mail within 10 days of enrollment into the plan along with a postage-paid envelope for response.
4. Each new member will also receive up to two telephone calls reminding them to review and return the assessment form. This telephonic outreach can be made to head of household for members under the care of parents or other authorized representatives. At least two attempts will be made to contact the member or their authorized representative within 45 days of enrollment.

B. Initial Screening

1. Returned forms will be reviewed to determine if the member requires expedited care within 30 days of receipt of a completed HRA form for SPD/CCS members, or within 90 days of return of the HIF/MET for all other newly enrolled members. If the member is found to require expedited care, a CC staff member will contact the member or member's authorized representative.
   a. The role of CC staff member in the HRA or HIF/MET process is to expedite access to care for new members. Examples include, but are not limited to:
      1) Facilitate referrals for Long Term Services and Supports (LTSS) needs identified
      2) Contact durable medical equipment (DME) vendors to facilitate timely delivery of appropriate medical equipment
      3) Work with the primary care provider and/or specialists' offices to coordinate appointments
      4) Arrange transportation as appropriate
      5) Provide support and encouragement to the member and caregiver
      6) Identify members who may benefit from mental health services and refer to appropriate agencies for services
      7) Work with member to identify any psychosocial needs and refer to community-based organizations as appropriate
      8) Assist with facilitating referrals to appropriate resources and/ or services outside of the Plan's benefits (i.e., personal care, and/or energy assistance programs)
      9) Screen and refer new members who may benefit from Basic Care Management or Complex Case Management Services

C. Disenrollment

1. Upon disenrollment from Partnership and when requested, Partnership will make the results of the HRA or HIF/MET assessment available to the new Medi-Cal Managed Care Health Plan.

Policy/Procedure Number: MCCP2023		Lead Department: Health Services
Policy/Procedure Title: New Member Needs Assessment		☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/16/2017	**Next Review Date:** 02/12/2026~~10/09/2025~~ **Last Review Date:** 02/12/2025~~10/09/2024~~	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VII. REFERENCES:

Title 42 Code of Federal Regulations (CFR) 438.208(b)

Policy/Procedure Number: MCCP2023		Lead Department: Health Services
Policy/Procedure Title: New Member Needs Assessment		☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/16/2017	**Next Review Date:** 02/12/2026~~10/09/2025~~ **Last Review Date:** 02/12/2025~~10/09/2024~~	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VIII. DISTRIBUTION:
A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 10/18/17; *11/14/18; 11/13/19; 09/09/20; 09/08/21; 10/12/22; 10/11/23; 10/09/24; 02/12/25
*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCCP2025			**Lead Department: Health Services**	
Policy/Procedure Title: Pediatric Quality Committee Policy			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/10/2019		**Next Review Date:** ~~06/12/2025~~02/12/2026 **Last Review Date:** ~~06/12/2024~~02/12/2025		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	☒ **PQC**
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD MPH MBA*			**Approval Date:** 02/12/2025~~06/12/2024~~	

I. RELATED POLICIES:

A. MPQP1003 – Physician Advisory Committee (PAC)
B. MPQP1002 – Quality/Utilization Advisory Committee
~~C.~~ MCCP2024 – Whole Child Model For California Children's Services (CCS)
~~D.~~C. ~~MPCP2002 – California Children's Services~~
~~E.~~D. ADM21 – Stipends for Committee Members Serving on Partnership's CAC, FAC, PQC, Provider Grievance Review, and Q/UAC Committees

II. IMPACTED DEPTS:

Health Services

III. DEFINITIONS:

A. California Children's Services (CCS): The CCS program is a program of the State of California, established under the Health and Safety Code, Section 123800 et seq. which is administered by the Department of Health Care Services (DHCS). It provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions.
B. Whole Child Model (WCM): A program of the California Department of Health Care Services (DHCS) established under the authority of Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016), which allowed designated County Organized Health Systems (COHS) or Regional Health Authority Counties to incorporate CCS covered services into Medi-Cal managed care for CCS-eligible members.[1]

IV. ATTACHMENTS:

A. NA

V. PURPOSE:

The Partnership HealthPlan of California (Partnership) Pediatric Quality Committee (PQC) was established

[1] ~~For Members under age 21 with a CCS-eligible condition(s), services and supplies for the CCS-eligible condition(s) will either be authorized by Partnership under the Whole Child Model program (see policy MCCP2024 Whole Child Model for California Children's Services (CCS), or by the State CCS program (see policy MPCP2002 California Children's Services). In Partnership's service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in Partnership's service area are participants in the State's CCS program and are not participants in Partnership's Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.~~

by the Chief Medical Officer (CMO) to provide Partnership with advice on clinical issues related to CCS conditions. It reports its findings to the Partnership Physician Advisory Committee (PAC) and the Family Advisory Committee (FAC). The PAC has the ultimate authority over clinical policies for Partnership, so recommendations of the PQC are subject to the approval of PAC.

VI. POLICY / PROCEDURE:

A. Committee Structure
   1. Membership:
      a. The PQC is comprised of the Partnership Chief Medical Officer, the Partnership Whole Child Model Medical Director, the Chief Health Services Officer, the Pharmacy Director, at least four CCS-paneled clinician providers, the CCS Medical Directors designated by each Partnership county, and the Nurse Director/Manager designated by each County CCS program.
      b. Other health plan staff and outside experts may make special or periodic reports to the committee or may attend selected meetings by invitation from the committee chair or designee.
   2. Minutes: Minutes of all meetings are maintained.
   3. Chair: The Partnership Whole Child Model Medical Director chairs the committee; the Partnership Chief Medical Officer is the vice chair.
   4. Meetings: The Committee meets at least four (4) times a year, with the option to add additional meetings if needed. The meeting agenda will be sent out at least one week prior to meeting date.
   5. Advisory Recommendations: Only non-Partnership clinical members (physicians and nurses) may reach a consensus on recommendations to be submitted to the PAC. The committee chair may lead and participate in the discussion and serves in a tie breaking capacity as necessary. A quorum needed to recommend action items shall be at least 4 non-Partnership members. Any action items pass with a simple majority of members present.
   6. Compensation: Physician members who are not Partnership staff are eligible to receive a financial stipend for each meeting attended (unless otherwise compensated by their county CCS agency for attendance at PQC or by Partnership for management responsibilities.) This stipend may be in addition to other compensation when the member serves as a clinical consultant/physician adviser. (Please see policy ADM21 – Stipends for Committee Members Serving on Partnership's CAC, FAC, PQC, Provider Grievance Review, and Q/UAC Committees for stipend form and instructions.)

B. Committee Responsibilities
   1. Discuss clinical issues relating to CCS conditions, as brought to the committee by committee members, by Partnership staff or by referral from the Family Advisory Committee.
   2. Make recommendations to the PAC on CCS/WCM related clinical policies. These recommendations may first flow through the Internal Quality Improvement (IQI)/ Quality Utilization Advisory Committee (QUAC) policy flow, if applicable, before going to the PAC.
   3. Upon approval by the committee, an ad hoc subcommittee may be formed as needed.

VII. REFERENCES:

DHCS All Plan Letter (APL) 24-0153-034 – California Children's Services Whole Child Model Program (12/0227/202443)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES: 05/13/20; 05/12/21; 05/11/22; 06/14/23; 06/12/24; 02/12/25

Policy/Procedure Number: MCCP2025		**Lead Department: Health Services**
Policy/Procedure Title: Pediatric Quality Committee Policy		☒**External Policy** ☐**Internal Policy**
Original Date: 04/10/2019	**Next Review Date: 02/12/2026** **Last Review Date: 02/12/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PREVIOUSLY APPLIED TO:
N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCCP2035</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Local Health Department (LHD) Coordination</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 03/13/2024
Effective Date: 01/01/2024</td><td colspan="4">Next Review Date: ~~03/13/2025~~02/12/2026
Last Review Date: ~~03/13/2024~~02/12/2025</td></tr>
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</table>

I. RELATED POLICIES:

A. MCUP3015 – Family Planning Bypass Service
B. MCUP3047 – Tuberculosis Related Treatment
C. MCQG1005 – Adult Preventive Health Guidelines
D. MCQG1015 – Pediatric Preventive Health Guidelines
E. MCCP2022 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
~~F.~~ MCCP2024 – Whole Child Model for California Children's Services
~~G.~~F. ~~MPCP2002 – California Children's Services~~
~~H.~~G. MCCP2033 – Community Health Worker (CHW) Services Benefit
~~I.~~H. MCCP2032 – CalAIM Enhanced Care Management (ECM)

II. IMPACTED DEPTS:

A. Claims
B. Configuration
C. Compliance
D. Care Coordination
E. Population Health Management
F. Transportation
G. Quality
H. Grievance and Appeals
I. Utilization Management
J. Member Services
K. Provider Relations

III. DEFINITIONS:

A. Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.
B. Medical Necessity: Means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
C. Medical Necessity for EPSDT Services: For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States

Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services.

D. Memorandum of Understanding (MOU): A formal written agreement between two or more governmental entities to outline and define roles and responsibilities. MOUs do not constitute a provider contract.

IV. ATTACHMENTS:

A. Local Health Department Memorandum of Understanding template (DHCS)

V. PURPOSE:

To describe and define the coordination with the Local Health Departments (LHD) in the health plan's network to ensure that members receive all Medically Necessary services, even if those services are not the financial responsibility of Partnership HealthPlan of California (Partnership).

VI. POLICY / PROCEDURE:

A. MEMORANDUM OF UNDERSTANDING (MOU)
   1. Partnership~~HC~~ shall negotiate in good faith and execute an MOU with LHDs in each county within Partnership~~HC~~'s service area to ensure care coordination, data sharing, and non-duplicative services for members for the following programs and services, at minimum:
      a. California Children's Services (CCS) / CCS Whole Child Model (CCS WCM);
      b. Maternal, Child and Adolescent Health (MCAH);
      c. Tuberculosis (TB) Direct Observed Therapy (DOT);
      d. Community Health Workers (CHW) services, as appropriate;
      e. Emergency Preparedness and Response Plan;
      f. All other medically necessary services that are the responsibility of the LHD, not otherwise specified

B. LHD MOU REQUIREMENTS
   1. Partnership~~HC~~'s MOU with the LHD shall contain all the following components, at minimum:
      a. Identification of services that are the responsibility of the LHD under the MOU, and populations that are to be served;
      b. Identification of the oversight responsibilities for the LHD and Partnership~~HC~~;
      c. Policies and procedures that the LHD and Partnership~~HC~~ establish for eligibility, screening, assessment, evaluation, and/or medical necessity determination;
      d. Policies and procedures for coordinating member care between the parties, including but not limited to, Closed Loop Referrals;
      e. Policies and procedures for the timely and frequent exchange of Member information and data, including Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, bi-directional monitoring of data exchange processes, and obtaining Member consent;
      f. Policies and procedures to address and document Quality Improvement (QI) activities for services covered under the MOU, including but not limited to, any applicable performance measures and QI initiatives, reports that track cross-system referrals, Member engagement, and service utilization;
      g. Agreement by both parties to participate in quarterly meetings to discuss Care Coordination as well as systemic and case-specific concerns including allowing Subcontractors and Downstream Subcontractors to participate, as appropriate;
      h. Policies and procedures detailing how complaints can be raised and how to resolve disputes between the parties, including but not limited to, a mutually agreed upon review process to facilitate timely resolution of disputes, differences of opinion and responsible entity for covering

services until the dispute is resolved. The review process must not result in delays in Member access to services pending formal dispute resolution;

i. Policies and procedures regarding Member access to Medically Necessary services and Network Providers during non-business hours;
j. Policies and procedures for Member, Subcontractor, Downstream Subcontractor, and Network Provider education related to access to services covered under the MOU;
k. Policies and procedures to address emergency preparedness protocols;
l. Provision requiring third-party entities and county programs to participate in Contractor's Population Needs Assessment (PNA).

2. MOUs must be publically posted.
3. MOUs cannot be delegated.
4. Partnership~~HC~~ shall invite the LHD liaison(s) and/or other identified LHD staff (ex: MCAH, TB, etc.) to participate in a quarterly meeting, as appropriate, to discuss and address care coordination and/or MOU-related issues.
5. Partnership~~HC~~ shall conduct an annual review of the LHD MOU to determine whether any modifications, amendments, updates or renewals of responsibilities and obligations outlined are required. Partnership~~HC~~ shall provide evidence of the annual review of the LHD MOU to DHCS, as well as any copies of any MOU modified or renewed as a result.

C. MOU OVERSIGHT & COORDINATION

1. Partnership~~HC~~ shall have processes in place that maintain collaboration with the LHD and parties identified in the MOU and identify strategies to monitor and assess the effectiveness of the MOU with the LHDs as follows:
   a. Conduct regular meetings at least quarterly to address policy and practical concerns that may arise between Partnership~~HC~~ and the LHD;
   b. Resolve conflicts between Partnership~~HC~~ and the LHD within a reasonable timeframe;
   c. Designate a contact person to be responsible for the oversight and supervision of the terms of any MOUs entered into and notify DHCS within five working days of any change in the designated MOUs liaison;
   d. Ensure Subcontractors, Downstream Subcontractors, and Network Providers comply with any applicable provisions of the MOU;
   e. Provide training and orientation of MOU requirements with Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, on an annual basis, at a minimum. If DHCS requests a review of any existing MOU, Contractor must submit the requested MOU within ten Working Days of receipt of the request;
   f. Ensure appropriate committee representation, including local presence, for each quarterly meeting and the opportunity to discuss and address Care Coordination and MOU-related issues with county executives;
   g. Ensure an appropriate level of leadership on MOU engagements from both the Contractor and entity; and
   h. Report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.
2. Blood Lead Screening:
   a. Partnership~~HC~~ shall cover and ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with 17 CCR §§ 37000 - 37100 and in accordance with APL 20-016 (Revised) Blood Lead Screening of Young Children.
   b. Partnership~~HC~~ will coordinate with its provider network and the MCAH Provider to ensure each eligible Member receives a blood lead screening.
   c. Partnership~~HC~~ shall identify, at least quarterly, all members under the age of six (6) years of age with no record of receiving a required lead test and will remind the LHD of the requirement to test children.

d. Each quarter, PartnershipHC will share a list of those Members enrolled in MCAH Programs who have not received a required blood lead test to assist MCAH Providers with providing such test to PartnershipHC Members.
e. Where blood lead screening is done by the Childhood Lead Poisoning Prevention Branch ("CLPPB") and administered by Care Management Section staff at the state level, PartnershipHC must coordinate directly with the CLPPB to address barriers to care coordination.
f. For more information, see PartnershipHC policy MCQG1015 Pediatric Preventive Guidelines.

3. Tuberculosis (TB) and Direct Observed Therapy (DOT)
   a. PartnershipHC and the LHD shall ensure, as needed, joint case management and coordination of care between the PartnershipHC and LHD TB control officer for Members on DOT.
   b. LHD is responsible for assigning a TB case manager to notify the PartnershipHC provider of suspected and active cases, and the TB case manager must be the primary LHD contact for coordination of care with PartnershipHC.
   c. PartnershipHC's Care Coordination department shall be available to assist in the coordination of care for each PartnershipHC member diagnosed with TB.
   d. The member's PartnershipHC provider will serve as the primary contact for coordination of care with LHD for suspected and active TB cases.
   e. Please see PartnershipHC policy MCUP3047 Tuberculosis Related Treatment.
4. Maternal Child and Adolescent Health
   a. Partnership shall ensure the provision of all screening, preventative, and medically necessary diagnostic treatment services for PartnershipHC members under twenty-one (21) years of age.
   b. The LHD must administer Maternal, Child and Adolescent Health (MCAH) programs in accordance with California Department of Public Health (CDPH) guidance set forth in the Local MCAH Programs Policies and Procedures manual and other guidance documents.
   c. PartnershipHC shall coordinate, as necessary, with the provider network, member and/or MCAH provider to ensure that the MCAH provider receives necessary information or documentation to assist the MCAH provider with performing an eligibility assessment or enrolling a PartnershipHC member into MCAH programs.
   d. The LHD is responsible for providing PartnershipHC with information regarding how to refer to an MCAH program, including as applicable, referral forms, links, fax numbers, email addresses, and other means of making and sending referrals to MCAH programs.
   e. The LHD is responsible for the timely enrollment of, and follow-up with, PartnershipHC members eligible for MCAH programs.
   f. PartnershipHC shall coordinate with the LHD to ensure that PartnershipHC members who are eligible for MCAH programs have access to prevention and wellness information and services.
   g. PartnershipHC shall screen members enrolled in MCAH programs for eligibility for care management programs such as basic population health management, complex case management, and/or Enhanced Care Management (ECM) such as members identified as having a high-risk pregnancy and/or children with special health care needs. For these members, PartnershipHC shall engage the LHD, as needed, in care management and care coordination.
5. Coordination of EPSDT:
   a. Where PartnershipHC and the LHD have overlapping responsibilities to provide services to members under age 21, PartnershipHC shall:
      1) Assess the member's need for EPSDT medically necessary services using the American Academy of Pediatrics Periodicity Table and the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) child vaccination schedule;
      2) Determine what type of services, if any, are being provided by MCAH programs, or other third-party programs/services; and

3) Coordinate the provision of services with the MCAH programs to ensure that PartnershipHC and the LHD are not providing duplicative services and that the member is receiving all medically necessary EPSDT services within sixty (60) calendar days following the preventative screening or visit that identified a need for treatment.

b. For more information, see PartnershipHC policy MCCP2022 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.

6. California Children's Services (CCS)
   a. Please see PartnershipHC policy MCCP2024 Whole Child Model for California Children's Services.

D. Reimbursement for LHD Services
1. PartnershipHC shall ensure that members have access and covered services for immunizations, blood lead screening, Sexually Transmitted Infection (STI) services, Family Planning, HIV Testing and Counseling.
2. When applicable, LHDs must ensure and avoid duplicative billing for LHD services.
3. When and where possible, PartnershipHC makes a good faith attempt to contract with the LHD within PartnershipHC's service area for the provision of LHD services.
4. For LHDs that provide the following services as a non-contracted provider:
   a. Immunizations:
      1) PartnershipHC does not require the LHD to obtain prior authorization.
      2) PartnershipHC shall reimburse the LHD for immunization services provided under the MOU at no less than the Medi-Cal Fee-for-Service (FFS) rate.
      3) PartnershipHC shall reimburse the LHD for the administration fee for immunization given to members who are not already immunized as of the date of immunization, in accordance with APL 18-004APL 24-008 Immunization Requirements.
      4) When not already in state wide systems such as the California Immunization Registry (CAIR2), PartnershipHC shall provide updated information on the status of member's immunization to LHD
      5) If LHD provides immunizations to a PartnershipHC member, the LHD must provide updated information on the member's immunization status to PartnershipHC.
   b. Sexually Transmitted Infections (STI) Services, Family Planning, and HIV Testing and Counseling
      1) PartnershipHC shall not require prior authorization or referral for members to access STI services. For more information on this, see PartnershipHC policy MCUP3015 Family Planning Bypass Services.
      2) PartnershipHC shall reimburse the LHD for STI services at no less than the Medi-Cal Fee-for-Service (FFS) rate for the diagnosis and treatment of an STI episode.
      3) PartnershipHC shall reimburse the LHD for family planning services at a rate no less than the appropriate Medi-Cal FFS rate for the services listed in Exhibit CA of the LHD MOU (refer to Attachment A above) that are provided to PartnershipHC members of childbearing age to temporarily or permanently prevent or delay pregnancy.
      4) If the LHD provides HIV testing and counseling services to PartnershipHC members, PartnershipHC shall reimburse the LHD at a rate no less than the Medi-Cal fee-for-service (FFS) rate.
      5) For reimbursement for STI services, family planning and/or HIV testing and counseling, the LHD must submit the appropriate billing information to PartnershipHC and/or treatment records or documentation of a member's refusal to release medical records to PartnershipHC.
   c. Blood Lead Screening:
      1) If an MCAH provider performs a blood lead screening, they will be reimbursed at a rate of no less than the Medi-Cal fee-for-service (FFS) rate.

2) The MCAH provider must share results of the screening with PartnershipHC~~HC~~.

d. Tuberculosis

1) PartnershipHC~~HC~~ does not cover Direct Observation Therapy (DOT). The LHD must submit claims for reimbursement of DOT services directly to the state Medi-Cal program.

VII. REFERENCES:

A. DHCS All Plan Letter (APL) 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023)
- Local Health Department Memorandum of Understanding template (DHCS Contract Attachment F)

B. DHCS APL 20-016 *(Revised)* Blood Lead Screening of Young Children (11/02/2020)

C. DHCS ~~APL 18-004 Immunization Requirements (01/31/2018)~~ APL 24-008 Immunization Requirements (06/21/2024)

D. The American Academy of Pediatrics Periodicity Table https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

E. The Centers for Disease Control and Prevention https://www.cdc.gov/vaccines/index.html Advisory Committee on Immunization Practices (ACIP) https://www.cdc.gov/faca/committees/acip.html

VIII. DISTRIBUTION:

A. PartnershipHC~~HC~~ Department Directors

B. PartnershipHC~~HC~~ Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 0~~ N/A~~2/12/25

PREVIOUSLY APPLIED TO:

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PartnershipHC~~HC~~ to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PartnershipHC~~HC~~.

PartnershipHC~~HC~~'s authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPCP2006 (previously CP100206)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/20/2001</td><td colspan="4">Next Review Date: 02/12/2026~~6/12/2025~~
Last Review Date: 02/12/2025~~6/12/2024~~</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 02/12/2025~~06/12/2024~~</td></tr>
</table>

I. RELATED POLICIES:

~~A.~~ MCCP2024 – Whole Child Model for California Children's Services
~~B.~~A. ~~MPCP2002 – California Children's Services~~
~~C.~~B. MCQG1015 – Pediatric Preventive Health Guidelines
~~D.~~C. MPUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21
~~E.~~D. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
~~F.~~E. MCUP3039 – Direct Members
~~G.~~F. MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
~~H.~~G. MCCP2035 – Local Health Department (LHD) Coordination
~~I.~~H. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
~~J.~~I. MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
~~K.~~J. MCCP2014 – Continuity of Care
~~L.~~K. MCCP2034 – Transitional Care Services (TCS)
~~M.~~L. MPCD2013 – Care Coordination Program Description
~~N.~~M. MCCP2007 – Complex Case Management
~~O.~~N. MCCP2032 – CalAIM ECM

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status is based on the member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.
C. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled

D. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
E. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
F. Medicaid: A joint federal and state program that helps cover medical costs for some people with limited income and resources. Medi-Cal is California's Medicaid health care program, supported by federal and state taxes.
G. Medical Home: The provider identified as the member's medical home or primary care provider (PCP) is responsible for managing the member's primary care needs.
H. Members with Special Health Care Needs (MSHCNs) are those who have, or are at increased risk for, chronic physical, developmental, behavioral or emotional conditions.
I. School-linked services: Behavioral health services offered either at a physical location associated with a school or services rendered elsewhere that are provided by school personnel or arranged by school personnel.
J. Whole Child Model (WCM): ~~In participating counties, T~~this program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for Partnership HealthPlan of California (Partnership) pediatric members with a CCS-eligible condition(s).

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To outline a process for the identification, assessment, case management and coordination of care for Members with Special Health Care Needs and Persons with Developmental Disabilities that encourages access to specialties, sub specialties, ancillary providers, and community resources.

VI. POLICY / PROCEDURE:

Partnership HealthPlan of California (Partnership) has a process for the identification, assessment, case management and coordination of care for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities. Partnership encourages timely access to specialties, sub specialties, ancillary providers, and community resources. The effectiveness of Partnership's processes in serving MSHCNs is monitored on an annual basis to ensure best practices and identify opportunities for improvement. This quality review may be accomplished by utilizing Healthcare Effectiveness Data and Information Set (HEDIS®) measures, member satisfaction surveys, member grievances, inputs from community agencies, and data-driven measures that analyze clinical trends, access to care and specific utilization questions.

A. Identification
   1. Partnership identifies MSHCNs in multiple ways including, but not limited to, the following:
      a. Primary Care Providers (PCP) may identify children with special needs, including California Children's Services (CCS) eligible conditions, and facilitate timely referrals to appropriate services/agencies.
      b. Partnership Health Services staff screen Treatment Authorization Requests (TARs) routinely to assess and identify members with potential special needs/conditions; collaborating when necessary with providers, Partnership Case Managers (CMs), CCS, and/or other community agencies to ensure members are connected and referred appropriately.
      c. Nurse Coordinators (NCs) review all hospitalizations concurrently for early interventional opportunities.
      d. Health Services Care Coordination (CC) staff respond to requests from providers, families, and other agencies for case coordination assistance, and/or other intended departments.
      e. Partnership downloads the list of Regional Center (RC) enrollees from the California

Department of Health Care Services (DHCS) monthly.

f. Risk stratification reports include protocols for both adult and pediatric members whereby Partnership's membership is screened monthly for emergence of new conditions that may qualify for these benefits.

2. Assessment

Primary Care Providers (PCPs) are trained by Partnership's Provider Relations department for the identification of MSHCN when they contract with Partnership. Our review concerns the following assessment:

a. A History & Physical (H&P) is completed within 120 calendar days of the member's effective date of enrollment into the HealthPlan, or documented within the 12 months prior to the plan enrollment. The H&P will assess and diagnose acute and chronic conditions.

b. Health assessments containing Child Health and Disability Program (CHDP) age-appropriate content requirements are provided according to the most recent American Academy of Pediatrics (AAP) periodicity schedule for pediatric preventive health care. Assessments and identified problems are documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate.

3. Direct Access to Specialists

Partnership allows certain populations of MSHCNs to be placed in a Direct Member category, which allows direct access to care without requiring a referral from a primary care provider. These populations include, but are not limited to, CCS-eligible members, youth in Foster Care and members in the Genetically Handicapped Persons Program (GHPP).

B. Case Management and Care Coordination

Partnership coordinates care with other agencies that provide services for MSHCNs as follows:

1. California Children Services (CCS) - Birth to age 21 years

a. ~~In participating counties[1],~~ Partnership members who have a CCS-eligible condition participate in the Whole Child Model (WCM). ~~-~~As part of this model, Partnership provides the case management and utilization management services for these members. For more information, refer to policy MCCP2024 Whole Child Model for California Children's Services (CCS).

~~b. Partnership members who have a CCS-eligible condition and participate in the CCS Program, refer to policy MPCP2002- California Children's Services for more details.~~

2. High Risk Infant Follow-Up (HRIF) Services – Birth to age 3 years

a. In accordance with APL 2~~43~~-0153~~4~~ California Children's Services Whole Child Model Program (12/02~~27~~/2024~~3~~), ~~for members in counties that participate in the WCM program,~~ Partnership is responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services. Refer to policy MCCP2024 ~~Whole Child Model for California Children's Services (CCS)~~ for more details.

~~b. For members who live in a county that participates in the State CCS Program, this would be the responsibility of the CCS offices and providers, Partnership may work in collaboration if~~

~~[1]For Members under age 21 with a CCS-eligible condition(s), services and supplies for the CCS-eligible condition(s) will either be authorized by Partnership under the Whole Child Model program (see policy MCCP2024 Whole Child Model for California Children's Services (CCS), or by the State CCS program (see policy MPCP2002 California Children's Services). In Partnership's service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in Partnership's service area are participants in the State's CCS program and are not participants in Partnership's Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.~~

~~necessary. Refer to policy MPCP2002- California Children's Services for more details.~~

3. Early Intervention (EI) Services - Birth to age 3 years
   a. The Partnership provider network has primary responsibility for the identification of children less than 3 years of age who may be eligible to receive services from the Early Start Program and to make the referral to the RC, which coordinates those services. These include children where a developmental delay in either cognitive, communication, social, emotional, adaptive, physical or motor development is suspected, or whose early health history places them at risk for delay.
   b. Partnership HS staff assist in identifying and referring children who may qualify for the Early Start Program.
   c. Partnership HS staff collaborate with providers, RC(s), and/or the Early Start Program in resolving problems, determining medically necessary services, including diagnostic and preventive services and provide input to be considered in the treatment plans for members participating in the Early Start Program. Children under age 21 who may benefit from Behavioral Health Treatment (BHT) services can be referred for screening and services. BHT services must be determined to be medically necessary to correct or ameliorate any physical or behavioral conditions and covered under Medicaid. Please see Partnership policy MPUP3126 Behavioral Health Treatment for Members Under the Age of 21 for details.
   d. Partnership's Care Coordination department and primary care providers provide case management (CM) and care coordination (CC) to the member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services that are identified in the Individual Family Service Plan (IFSP) developed by the Early Start Program.
4. Services for Persons with Developmental Disabilities
   a. Partnership provides all screening, preventive, medically necessary, and therapeutic covered Medi-Cal services to members with developmental disabilities. Children under 21 may be eligible for BHT services. Please see Partnership policy MPUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21 for details.
   b. Partnership members who are also clients of a RC are referred to the RC for evaluation and access to non-Medi-Cal services provided through the RC(s) including, but not limited to, respite, day care, out-of-home placement, vocational training, financial management and supportive living.
   c. Partnership members who are not clients of a RC but who may meet their eligibility criteria for developmental disability, are advised to contact the RC for assessment and evaluation. Partnership is not able to make a direct referral to a RC without written consent of the member or legal representative.
   d. Upon request to Partnership by the member, RC staff or other entities, Partnership HS staff will assist with identification and coordination of appropriate services for the member.
5. Local Education Agency Services (LEA)
   a. Partnership is not contractually responsible for educationally necessary BHT services covered by a LEA and provided pursuant to a member's IFSP, IEP, or IHSP. However, if medically necessary and covered under Medicaid, Partnership must provide supplementary BHT services, and must provide BHT services to address gaps in service caused when the LEA discontinues the provision of BHT services (e.g. during a Public Health Emergency [PHE]). Please see Partnership policy MPUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21 for details.
   b. Partnership assures a PCP is available to provide primary care management and care coordination to the member to ensure the provision of all medically necessary Medi-Cal covered diagnostic, preventive and treatment services. Partnership encourages the member's PCP to collaborate and share pertinent medical and treatment information with the LEA to assist in the development of the Individual Education Plan (IEP) or Individual Family Service Plan (IFSP).

For more information, see Partnership policy MCCP2022 -Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

c. LEA assessment services are services provided by the LEA as specified in Title 22 CCR Section 51360(b) and are provided to students who qualify based on Title 22 CCR Section 51190.1 and are provided pursuant to an IEP as set forth in Education Code, Section 56340 et seq. or an ISFP as set forth in Government Code, Section 95020.

6. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N)
   a. ICF/DD, ICF/DD-H, and ICF/DD-N are services offered to members with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center service system in accordance with APL 23-023 *Revised* Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care. For CCS-eligible members under the age of 21, please refer to Partnership policy MCCP2024 ~~and MPCP2002~~ for more details.
   b. Partnership ensures that members living in ICF/DD Homes have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), Transitional Care Services (TCS), care management programs, and Community Supports as appropriate in coordination with the Regional Center. Please refer to Partnership policy MPCD2013 Care Coordination Program Description for more details.
   c. Transitional Care Services (TCS): High-risk individuals include individuals in all LTSS services, including LTC, as well as individuals that have a behavioral health diagnosis or a developmental disability. For more information on high-risk transitioning members' criteria, refer to MCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services Section VI.D.1. TCS is available when members are in need of transitional support; refer to Partnership Policy MCCP2034 Transitional Care Services (TCS) for more details.
   d. Complex Case Management (CCM): Members may need extra support to avoid adverse outcomes but who are not in the highest risk group. Refer to Partnership Policy MCCP2007 Complex Case Management for more details.
   e. Continuity of Care (COC) Requirements: During the continuity of care period, MCPs must provide 12 months of continuity of care for the ICF/DD Home placement of any member residing in an ICF/DD Home who is mandatorily enrolled into Partnership after January 1, 2024. Following their initial 12-month continuity of care period, members or their authorized representatives may request an additional 12 months of continuity of care, pursuant to the process established by APL 23-022, Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, on or after January 1, 2023. Refer to Partnership policy MCCP2014 Continuity of Care and MCUG3038 Review Guidelines for Member Placement in Long Term Care (LTC) Facilities for more details.
   f. Enhanced Care Management (ECM): Members living in ICF/DD are not currently eligible for ECM, if there are other individual care needs or concerns, their needs can be reviewed for consideration. If a member will be transitioning out of an ICF/DD Home, the restriction of duplicative service is removed, and the member must be assessed to determine need/eligibility for ECM services. Refer to Partnership Policy - MCCP2032 CalAIM ECM for more details.
   g. Utilization Review for ICF/DD, ICF/DD-H, and ICF/DD-N facilities: Refer to Partnership policy MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities for more details.

7. School-Linked Children's Health and Disability Prevention (CHDP) Services.
   Partnership does not currently have a school-linked CHDP program in its county service area. If a school-linked CHDP program site establishes within its county service area, Partnership will do the following:
   a. Maintain a "medical home" and ensure the overall coordination of care and case management of members who obtain CHDP services through the local school districts or school sites.
   b. Establish guidelines for the following:
      1) Sharing of critical medical information
      2) Coordination of services
      3) Reporting requirements
      4) Quality standards
      5) Processes to ensure services are not duplicated
      6) Processes for notification to member/student /parent/guardian on where to receive initial and follow-up services
      7) Referral protocols/guidelines for the school sites which conduct CHDP screening only, to assure those members who are identified at the school site as being in need of CHDP services receive those services within the required state and federal time frames
      8) Assure processes for appropriate follow-up and documentation of services provided to the member
      9) Provide resources to support the provision of school-linked CHDP services
      10) This supersedes any contradicting information found within the Child Health and Disability Prevention (CHDP) Program guidelines, as the CHDP sunsets July 1, 2024.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) Contract Exhibit A, Attachment III, Section 4.3.9
B. Title 22, California Code of Regulations (CCR) Sections 51360(b) and 51190.1
C. Department of Health Care Services All Plan Letter (APL) 23-010: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 (*Revised* 11/22/2023)
D. DHCS All Plan Letter (APL) 24-0153~~-034~~ – California Children's Services Whole Child Model Program (12/0227~~/2043~~)
E. Department of Health Care Services All Plan Letter (APL) 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
F. National Committee for Quality Assurance (NCQA) Health Plan Standards 2024. Population Health Management 5 Complex Case Management
G. DHCS High Risk Infant Follow Up https://www.dhcs.ca.gov/services/ccs/pages/hrif.aspx
H. DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

Policy/Procedure Number: MPCP2006 (previously CP100206)		**Lead Department: Health Services**
Policy/Procedure Title: Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities		**☒External Policy** **☐Internal Policy**
Original Date: 06/20/2001	**Next Review Date: 02/12/2026~~6/12/2025~~** **Last Review Date: 02/12/2025~~6/12/2024~~**	
Applies to:	**☒ Medi-Cal**	**☐ Employees**

X. REVISION DATES:

Medi-Cal

08/20/03; 04/20/05; 01/16/08; 05/19/10; 10/01/10; 09/19/12; 10/15/14; 09/16/15; 09/21/16; 09/20/17; *06/13/18; 11/14/18; 03/13/19; 11/13/19; 09/09/20; 09/08/21; 09/14/22; 09/13/23; 06/12/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Healthy Kids MPCP2006 (Healthy Kids program ended 12/01/2016)

01/16/08; 05/19/10; 10/01/10; 09/19/12; 10/15/14; 09/16/15; 09/21/16 to 12/01/16

Healthy Families:

MPCP2006 - 10/01/2010 to 03/01/2013

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: ~~MCUP3142~~MCHP3142</td><td colspan="3">Lead Department: Health Services
Business Unit: EHS</td></tr>
<tr><td colspan="3">Policy/Procedure Title: CalAIM Community Supports (CS)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 03/09/2022
Effective Date: 01/01/2022 vs. DHCS</td><td colspan="4">Next Review Date: ~~01/10/2025~~02/12/2026
Last Review Date: ~~01/10/2024~~02/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage [1]</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~01/10/2024~~02/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCCP2032 – CalAIM Enhanced Care Management (ECM)
B. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
C. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
D. MCUP3041 – Treatment Authorization Request (TAR) Review Process
E. MCUP3103 – Coordination of Care for Members in Foster Care
F. MPCR100 – Credential and Re-credential Decision Making Process
G. MPPR200 – ~~PHC~~ Partnership Provider Contracts

II. IMPACTED DEPTS:

A. Health Services
B. Care Coordination
C. Claims
D. Finance
E. Member Services
F. Provider Relations
G. Administration

III. DEFINITIONS:

A. Community-Based Organizations (CBO): A public or private non-profit organization dedicated to the overall health, well-being, and functions of their community.
B. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).
C. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid (CMS) rules. However, because dual eligible members in D-SNPs are not eligible for Medi-Cal ECM, a separate Partnership Advantage ("PA") policy will be crafted.

coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

D. Closed Loop Referral ~~(CLR)~~: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

~~D.~~E. Community Supports (CS) Provider: A contracted provider experienced and/or trained in providing one or more of the Community Supports

~~E.~~F. In Home Supportive Services (IHSS) Program: The In-Home Supportive Services (IHSS) program is a Medi-Cal program funded by federal, state, and county dollars to provide in-home assistance to eligible aged (over the age of 65), blind and disabled individuals as an alternative to out-of-home care.

~~F.~~G. Whole Person Care (WPC): A five-year pilot program under California's 1115 Medicaid waiver to service high-risk populations using a collaborative approach across public and private entities to integrate and coordinate health, behavioral health, and social services. ~~PHC~~ Partnership counties participating in the WPC pilot program include Marin, Mendocino, Napa, Shasta, and Sonoma.

IV. ATTACHMENTS:

A. Community Supports Criteria Matrix and Community Supports HCPCS Code Chart
B. Community Supports (CS) Release of Information (ROI)

V. PURPOSE:

To describe how Partnership HealthPlan of California ~~(PHC)~~ administers Community Supports (CS) for ~~PHC~~ Partnership Medi-Cal eligible beneficiaries and to outline the collaboration between members, ~~PHC~~Partnership, providers, county agencies, community resources, and Community Based Organizations (CBOs). Pursuant to the Department of Health Care Services (DHCS) All Plan Letter (APL) 21-017 *Revised*, Community Support services are not plan benefits, but are instead optional services that ~~PHC~~ Partnership may authorize for members to save health care costs while promoting better health outcomes for the member. Community Supports builds upon the design and learning from California's Whole Person Care (WPC) and Health Homes Program (HHP) and are a part of DHCS' waiver under CalAIM. The goals of Community Supports are:

A. To place members in the least restrictive setting possible and keep them in the community.
B. Focus largely on Social Determinants of Health (SDOH) such as housing/shelter, food instability, transportation and community resources to improve medical health outcomes and healthcare costs.

VI. POLICY / PROCEDURE:

A. ~~PHC Partnership~~PARTNERSHIP ADMINISTRATION OF COMMUNITY SUPPORTS:
   1. Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are services or settings that are offered in ~~place~~ place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).
   2. Effective January 1, 2022, ~~PHC~~ Partnership offers the following DHCS approved CS services:
      a. Housing Transition Navigation Services
      b. Housing Deposits
      c. Housing Tenancy and Sustaining Services
      d. Short-Term Post-Hospitalization Housing

e. Recuperative Care (Medical Respite)
f. Meals/Medically Tailored Meals.

3. Effective January 1, 2023, ~~PHC~~ Partnership offers the additional DHCS approved CS services:
   a. Respite Services
   b. Personal Care and Homemaker Services
4. Effective January 1, 2025, Partnership offers the additional DHCS approved CS Services:
   a. Day Habilitation Program
   b. Sobering Centers

~~4.~~5. Upon approval by DHCS, ~~PHC~~ Partnership may elect to add additional CS services to their network every six (6) months.

B. COMMUNITY SUPPORTS ELIGIBIILTY CRITERIA:

1. To be eligible to receive a CS service, the member and/or CS provider must demonstrate that the service will result in:
   a. A decrease in utilization and/or cost for a subsequent Medi-Cal benefit. Examples include, but are not limited to:
      1) Hospitalization (Medical or Behavioral Health conditions)
      2) Nursing Facility care
      3) Emergency Department use
2. CS services must be reviewed and pre-authorized as per policy MCUP3143 Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
3. CS services are optional services that ~~PHC~~ Partnership may offer and services that a member can decline or end at any time.
   a. The CS service provider is responsible for obtaining the member's consent for service and data sharing (when required by federal law) and remitting the consents to ~~PHC~~ Partnership along with other documents pursuant to policy MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
4. Please see Attachment A for Partnership~~PHC~~'s methodology to ensure an appropriate, equitable, and non-discriminatory approach when reviewing and authorizing CS services.
   a. In the event ~~PHC~~ Partnership identifies the CS service authorization has an inappropriate, inequitable, and/or discriminatory effect, ~~PHC~~ Partnership will take immediate action and set a Correction Action Plan (CAP), one-on-one meetings, and follow-ups to guarantee CS services providers and/or delegates adhere and align to ~~PHC~~ Partnership policies and procedure; if a provider fails to adhere to the Corrective Action Plan, it may be decided to terminate the provider's contract.

C. MEMBER IDENTIFICATION AND REFERRAL FOR COMMUNITY SUPPORT SERVICES:

1. ~~PHC~~ Partnership shall utilize a variety of methods to identify members who may benefit from CS, including:
   a. Working with ECM Providers to identify members receiving ECM who could benefit from CS
   b. Proactively identifying members who may benefit from the ~~PHC's~~ Partnership's CS services, through the use of information such as:
      1) Enrollment data
      2) Utilization/claims data
      3) Screening or assessment data, when available (ex: HRA, IHA, HIF, ACEs, etc.)
      4) Clinical information on physical and/or behavioral health
      5) Severe Mental Illness (SMI)/Substance Use Disorder (SUD) data, when available
      6) Risk stratification information for children in Partnership~~PHC~~'s Whole Child Model (WCM)
      7) Other cross-sector data and information, including housing, social services, foster care,

criminal justice history, and other relevant information

c. Identification and referral by internal ~~PHC~~ Partnership departments (ex: Care Coordination, Claims, Utilization Management, Quality, Member Services, Population Health Management, etc.)

2. ~~PHC~~ Partnership encourages direct referrals for members to access CS services. These direct referrals can come from a multitude of sources, including but not limited to:
   a. PCPs, specialists, ECM providers, and/or CBOs via phone, mail, or fax.
   b. Members and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) via phone, mail, or ~~PHC~~ Partnership member portal.
3. Upon internal identification or direct referral for a member who may potentially benefit and/or be eligible for a CS service, a referral shall be sent to ~~PHC's~~ Partnership's Care Coordination department. The staff in the Care Coordination department shall attempt to contact the member, CS provider, and/or the member's caregiver, AR, or Lead Care Manager to refer the member to the CS service within ten (10) Business Days. Once a member is referred to a CS provider, the CS provider has two (2) business days to:
   a. Notify ~~PHC~~ Partnership that they received and accept the referral, and
   b. Attempt to contact the member or their representative to begin services, or
   c. Notify ~~PHC~~ Partnership that the CS provider is at full capacity pursuant to their contract with ~~PHC~~ Partnership so that the member can be re-referred to an alternative provider
4. ~~PHC's~~ Partnership's Care Coordination department shall document and track the CS referral in the appropriate system.
   a. If the member is receiving ECM, their Lead Care Manager shall document, coordinate and ensure closed-loop referrals and service delivery of the CS service(s) per the member's Individualized Care Plan. For more information, see MCCP2032 CalAIM Enhanced Care Management (ECM).
5. Members may be referred more than once for CS Services; members must engage with ~~PHC~~ Partnership and/or CS providers to qualify for services.
   a. Members who do not engage or are unresponsive to the CS Provider and/or ~~PHC~~ Partnership may not be authorized for CS Services again until the member is willing to engage and maintain communication.
   b. The member is responsible for a means to communicate with the CS Provider and/or Partnership~~PHC~~.
6. If referral lacks required information, ~~PHC~~ Partnership will make one (1) attempt to contact the referring party (e.g. case worker, lead care manager, etc.) or member to gather more information, however, member will be responsible to continue communication with ~~PHC~~ Partnership and/or CS provider to prevent cancelation of services.

D. DISCONTINUATION OF COMMUNITY SUPPORT SERVICES:
1. The CS provider shall notify Partnership~~PHC~~, and the inter-disciplinary care team (ex. PCP, Lead Care Manager, etc.) when a member discontinues CS services. Examples of discontinuation include, but are not limited to:
   a. The member has met their goals for the service and/or their service limitations pursuant the approved CS Treatment Authorization Request (TAR)
   b. The member expresses that he/she no longer wishes to receive the CS service
   c. The member is unresponsive or unwilling to engage with the CS provider and/or attempts from an ECM provider or Lead Care Manager (when applicable). Providers must make a minimum of three (3) outreach attempts. If no response, the CS provider must contact ~~PHC~~ Partnership immediately for further direction.
   d. The member is deceased
   e. The member loses ~~PHC~~ Partnership Medi-Cal eligibility

f. The member moves out of ~~PHC's~~ Partnership's service area
g. The member becomes incarcerated for more than 30 days
h. The CS provider can no longer provide services (e.g.: patient behavior, unsafe environment, etc.)

2. The CS provider may submit other reasons to request that the member discontinue services, for which ~~PHC~~ Partnership will review on a case-by-case consideration.

E. COMMUNITY SUPPORTS PROVIDERS:

1. ~~PHC~~ Partnership shall contract with both traditional and/or non-traditional providers for the provision of CS services. CS Providers can include, but are not limited to, those listed in the Medi-Cal Community Supports, or In Lieu of Services (ILOS) Policy Guide – under "Licensing/Allowable Providers."
2. Providers must communicate with ~~PHC~~ Partnership and provide weekly updates through email, phone calls, meetings, etc. until the member is engaged and participating. When the member is engaged, a TAR should be submitted to authorize services for a specified period of time, which will allow the provider to submit claims for their services.
3. All CS providers must have experience and expertise with the services they provide. To demonstrate such, all CS providers must complete ~~PHC's~~ Partnership's CS Provider "Readiness Assessment" prior to contracting.
4. All CS providers must have the capacity to provide culturally appropriate and timely in-person care management activities in accordance with Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Composition.
5. Partnership will ensure Members receive CS services within a timely manner. All CS providers shall prioritize referrals for ~~PHC~~ Partnership members in a non-discriminatory manner and shall not, without the expressed consent of Partnership~~PHC~~, keep or maintain "waitlists" for members referred or approved for a CS service.
   a. To the extent possible, ~~PHC~~ Partnership shall prioritize the member's preference for a CS provider.
~~6.~~ Pursuant to their contracts, CS providers must maintain their stated capacity/volume levels for the provision of the CS service. CS providers must communicate to ~~PHC~~ Partnership within five (5) business days if they have changes to their organization's capacity or staffing levels.
~~7.~~6. All CS providers must be enrolled with Medi-Cal pursuant to relevant DHCS APLs including APL 22-013 Provider Credentialing/Recredentialing and Screening/Enrollment.
   a. For providers that do not have a pathway to state-level enrollment, ~~PHC~~ Partnership requires that they meet and adhere to ~~PHC's~~ Partnership's contract standards. See policies MPPR200 ~~PHC~~ Partnership Provider Contracts and MPCR100 Credential and Re-credential Decision Making Process.

F. COMMUNITY SUPPORTS CORE SERVICE COMPONENTS:

The following CS services shall be offered pursuant to the definitions and standards set forth by DHCS in the CalAIM Waiver and per the DHCS contract for the following ~~PHC~~ Partnership approved CS services:

1. Housing Transition Navigation Services:
   a. Conducting tenant screening(s) and/or assessment(s) to identify the member's preferences and barriers related to a successful tenancy
   b. Development of an individualized housing support plan that contains both short-term and long-term goals, as well as a housing support crisis plan
   c. Searching for housing, presenting options, and assisting with requests for reasonable accommodations if necessary
   d. Assistance in securing housing via direct support with applications, documentation requirements, advocacy, etc.

e. Landlord education and engagement including advocacy on behalf of a member when necessary
f. Identification and coordination of benefits and resources to secure costs such as security deposits, moving costs, adaptive aids, environmental modifications, and/or other one-time expenses. These services do not assist members with ongoing rental costs.
g. Identification, coordination, and/or securing non-emergency, non-medical transportation (NMT)

2. Housing Deposits:
   a. Housing deposits may be approved based on the individualized assessment of need and documented in the member's individual housing support plan.
      1) The housing deposit may be used to secure a one-time service/funding to enable a person to establish a basic household that does not constitute room and board or ongoing rental cost.
         a) Housing Deposits can only be approved one additional time with documentation demonstrating what has changed and how this service would be more successful on the second attempt.
      2) Member must have been enrolled in Housing Transition Navigation Services for a minimum of 30 to 60 days and have a housing support plan.
      3) If approved, members may use the one-time benefit for a subset of the services below:
         a) Security deposits required to obtain a lease on an apartment or home
         b) Set-up fees/deposits for utilities or service access and utility arrearages
         c) First month coverage of utilities (e.g.: telephone, gas, electricity, heating, and water).
         d) First month's and last month's rent as required by landlord for occupancy
         e) Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy
3. Housing Tenancy and Sustaining Services
   a. Tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include, but are limited to:
      1) Early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations
      2) Education and training on the role, rights, and responsibilities of the tenant and landlord
      3) Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy
      4) Coordination with landlord and/or case management provider(s)
      5) Development of a plan to mitigate risk to housing such as assistance in resolving disputes with landlords/neighbors, repayment plans for damage to unit or back rent, etc.
      6) Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process
      7) Assistance with the annual housing recertification process
      8) Health and safety visits, including unit habitability inspections
      9) Providing independent living and life skills including assistance with and training on budgeting, financial literacy, and connection to community resources
   b. This service is available only for a single duration in a member's lifetime.
      1) Housing Tenancy and Sustaining Services may be approved for one additional time with documentation demonstrating what has changed and how this service would be more successful on the second attempt.
4. Short-Term Post-Hospitalization Housing
   a. For members exiting an inpatient hospital setting such as:
      1) An acute or psychiatric or Chemical Dependency and Recovery hospital
      2) Residential substance use disorder treatment or recovery facility
      3) Residential mental health treatment facility

4) Correctional facility, or
5) Nursing facility

b. These services are intended to provide ~~on-going~~ongoing support necessary for recuperation and recovery (e.g. gaining or re-gaining the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management, and beginning to access other housing supports such as Housing Transition Navigation, etc.)

5. Recuperative Care (Medical Respite)
   a. At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring, etc.).
   b. Based on individual needs, the service may also include:
      1) Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
      2) Coordination of transportation to post-discharge appointments
      3) Connection to any other on-going services an individual may require including mental health and substance use disorder services
      4) Support in accessing benefits and housing
      5) Gaining stability with case management relationships and programs
6. Meals/Medically Tailored Meals.
   a. Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission
   b. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases
   c. Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes
      1) Chronic conditions such as, but not limited to, Diabetes, Cardiovascular Disorders, Congestive Heart Failure, Stroke, Chronic Lung Disorders, Human Immunodeficiency Virus (HIV), Cancer, and chronic or disabling mental/behavioral health disorder.
7. Respite Services (Effective January 1, 2023)
   a. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals. Services are provided in the member's own home or in an approved out-of-home location.
   b. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
   c. Services cannot be provided virtually, or via telehealth.
   d. Services that attend to the participant's basic self-help needs and other activities of daily living.
   e. Hours approved by the plan will be based on the individual's assessment of needs.
   f. Service limit is up to 336 hours per calendar year.
   g. Subsets may include children who were previously covered under:
      1) Pediatric Palliative Care
      2) Foster Care Programs
      3) California Children's Services (CCS)
      4) ~~Generally~~ Genetically Handicapped Persons Program (GHPP)
      5) Clients with complex care needs
8. Personal Care and Homemaker Services (Effective January 1, 2023)
   a. Above and beyond any approved county In-Home Supportive Services (IHSS) hours, when additional hours are required and if IHSS benefits are exhausted; and

b. As authorized during any IHSS waiting period (member must be already referred to IHSS); this approval time period includes services prior to and up through the IHSS application date.
c. For members not eligible to receive IHSS, to help avoid a short-term stay in a skill nursing facility (not to exceed 60 days).
d. Services can only be utilized if appropriate and if additional hours/supports are not authorized by IHSS.
e. Total number of awarded IHSS hours for the member will be requested to ensure adequate hours for the individual's needs.
f. Services cannot be utilized in lieu of referring to the IHSS Program.
g. Personal Care and Homemaker Services are only allowed four (4) hours a day for up-to 20 hours a week, or as determined by the intake assessment.

9. Sobering Centers (Effective July 1, 2024)
   a. Will provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilitates, substance use education and counselling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.
   b. CS provider is required to provide direct coordination with the county behavioral health agency and warm hand-offs for additional behavioral health services are strongly encouraged.
   c. Service will also include screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options where applicable.
   d. CS provider will be required to partner with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers.
   e. CS provider must be prepared to identify Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
   f. CS provider will utilize best practices for members who are experiencing homelessness and who have complex health and/or behavioral health conditions including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma-informed care.
   g. Eligible Members are 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a sobering center.
   h. Service is covered for a duration of less than 24 hours.
10. Day Habilitation Program (Effective January 1, 2025)
   a. Provide in a Member's home or an out-of-home, non-facility setting training on:
      1) The use of public transportation
      2) Personal skills development in conflict resolution
      3) Community participation
      4) Developing and maintaining interpersonal relationships
      5) Daily living skills (cooking, cleaning, shopping, money management
      6) Community resource awareness such as police, fire, or local services to support independence in the community.
   b. Programs may include assistance with, but not limited to:
      1) Selecting and moving into a home
      2) Locating and choosing suitable housemates

3) Locating household furnishings
4) Settling disputes with landlords
5) Managing personal financial affairs
6) Recruiting, screening, hiring, training, supervising, and dismissing personal attendants
7) Dealing with and responding appropriately to governmental agencies and personnel
8) Asserting civil and statutory rights through self-advocacy
9) Building and maintaining interpersonal relationships, including a circle of support
10) Coordination with Partnership to link member to any Community Supports or Enhanced Care Management (ECM) for which the Member may be eligible
11) Referral to non-Community Supports ~~hosing~~housing resources if Member does not meet Housing Transition/Navigation Community Supports eligibility criteria
12) Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if Member is not receiving these services through CS or ECM
13) Coordination with ~~Medi-Cal managed care plan~~ Partnership to link Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through CS or ECM

c. The services provided should utilize best practices for Members who are experiencing homelessness or ~~formulary~~formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.
d. Members eligible are individuals who are experiencing homelessness, who exited homelessness and entered housing within the last 24 months, and those at risk of homelessness or institutionalization while housing stability could be improved through participation in a day habilitation program.

~~Sobering Centers~~

- ~~Will provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilitates, substance use education and counselling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.~~
- ~~CS provider is required to provide direct coordination with the county behavioral health agency and warm hand-offs for additional behavioral health services are strongly encouraged.~~
- ~~Service will also include screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options where applicable.~~
- ~~CS provider will be required to partner with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers.~~
- ~~CS provider must be prepared to identify Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.~~
- ~~CS provider will utilize best practices for members who are experiencing homelessness and who have complex health and/or behavioral health conditions including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma-informed care.~~
- ~~Eligible Members are 18 and older who are intoxicated but conscious, cooperative,~~

~~able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a sobering center.~~

~~Service is covered for a duration of less than 24 hours.~~

~~g.~~

G. CONTINUITY OF CARE

1. Effective January 1, 2022, for members who were enrolled in a Whole Person Care Pilot program, and identified by the WPC Lead entity as in receipt of a corresponding CS that ~~PHC~~ Partnership intends to offer, ~~PHC~~ Partnership automatically authorized CS services for six (6) months pursuant to DHCS implementation schedule.
   a. ~~PHC~~ Partnership notified all members transitioning from WPC who were receiving ~~PHC~~ Partnership CS service of the transition of their services 30 days prior to their transition date.
   b. CS providers submitted a Treatment Authorization Request (TAR) to ~~PHC~~ Partnership within six (6) months of the member's transition. ~~PHC~~ Partnership reviewed the authorization using the CS criteria set forth in policy MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).
2. In HHP and WPC Pilot Counties, ~~PHC~~ Partnership contracted with WPC Lead Entities and HHP CB-CMEs as CS Providers unless ~~PHC~~ Partnership received prior written approval from DHCS.
3. Members transitioning to ~~PHC~~ Partnership from another managed care plan and /or fee-for-service Medi-Cal who are currently receiving a Community Support that is currently being offered by Partnership~~PHC~~, shall automatically be authorized for CS services. For these members:
   a. ~~PHC~~ Partnership shall use available utilization data to proactively identify any new members who are in receipt of a Community Support service within the previous 90 days of their assignment to Partnership~~PHC~~, and initiate continued Community Support authorization.
   b. Newly assigned ~~PHC~~ Partnership members or their AR may contact ~~PHC~~ Partnership directly to request continued Community Support Services, and ~~PHC~~ Partnership shall expedite this request.
   c. ~~PHC~~ Partnership is not obligated under DHCS continuity of care requirements to keep the member assigned to the same CS provider, however, whenever possible ~~PHC~~ Partnership shall make a good faith effort to keep the member's CS provider the same.
   d. ~~PHC~~ Partnership shall contact and work with the member's previous health plan and/or CS provider to obtain access to the Member's ICP and ensure services are connected appropriately.
   e. ~~PHC~~ Partnership intends to adhere to Continuity of Care guidelines for transitioning members receiving CS services not offered by ~~PHC~~ Partnership but offered by a previous MCP. Members who have an active prior authorization for services not offered by ~~PHC~~ Partnership at the time of the transition will be authorized for a six-month span of the service. Requests for additional date spans will be reviewed on a case-by-case basis.

H. DATA SHARING TO SUPPORT COMMUNITY SUPPORTS

1. ~~PHC~~ Partnership shall support CS providers to access systems and processes allowing the CS provider to obtain and document Member information including eligibility, CS authorization status, Member authorization for data sharing (to the extent required by federal law), and other relevant demographic and administrative information, and to support notification to the member's PCP and/or interdisciplinary care team when a referral has been fulfilled. Examples include but are not limited to:
   a. Encounter / claims data
   b. Physical, behavioral, administrative, and SDOH data (e.g., HMIS data).
   c. Quality Reports
2. ~~PHC~~ Partnership has an IT and data analytic infrastructure to support the delivery of the CS services.

Key features of ~~PHC's~~ Partnership's systems include, but are not limited to:

a. Securely share data ~~between,~~between Partnership~~PHC~~, the CS provider, the member, and other providers in support of the CS service
b. The ability to receive, process, and send encounters from CS providers to DHCS
c. The ability to receive and process supplemental reports from CS providers
d. The ability to receive and process electronic claims and/or invoices from an CS provider
e. The ability to track CS grievances and appeals for P~~artnership~~HC
f. ~~PHC~~ Partnership will support CS Provider access to systems and processes allowing them to track and manage referrals for CS and Member information.

3. ~~PHC~~ Partnership will use defined Federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with CS Providers and with DHCS, to the extent practicable.
4. Effective September 1st, 2023, ~~PHC~~ Partnership will follow guidance provided by DHCS in the most current version of the document "CalAIM Data Guidance: Community Supports Member Information Sharing."
   a. ~~PHC~~ Partnership will share the required CS Authorization Status File (CS-ASF) data elements with contracted providers monthly using a Secure File Transfer Portal (s-FTP)
   b. CS contracted Providers will share the required CS Provider Return Transmission File (CS-RTF) data elements with ~~PHC~~ Partnership monthly using a Secure File Transfer Portal (s-FTP)

I. COMMUNITY SUPPORTS PROVIDER OVERSIGHT & QUALITY MONITORING

1. ~~PHC~~ Partnership will perform oversight of CS providers, holding them accountable to all applicable requirements contained in the DHCS Contract amendment and DHCS APL 21-017 *Revised*.
   a. ~~PHC~~ Partnership will perform quarterly audits, or more frequently as needed, to evaluate CS provider performance and compliance to ensure State, Federal, and contractual requirements are met. At a minimum, the following will be reviewed:
      1) ~~PHC~~ Partnership internal monitoring reports
         a) Utilization Reports
         b) Cost Reports
         c) Referral Reports
      2) Quality reports (e.g. Member Experience surveys)
      3) CS TARs to ensure they are equitable and non-discriminatory and have not had an inequitable effect
   b. Data and outcomes concerning CS services will be aggregated quarterly and reported at ~~PHC's~~ Partnership's Over/Under Utilization Review Committee and/or other Committees deemed appropriate.
2. ~~PHC~~ Partnership has developed its CS provider contracts using the DHCS ILOS Provider Standard Terms and Conditions and incorporated all of its CS provider requirements, including all monitoring and reporting expectations and criteria.
3. CS providers are responsible for timely and accurate submission of data to ~~PHC~~ Partnership for the purposes of reporting to DHCS.
4. ~~PHC~~ Partnership shall provide and make available CS training and technical assistance to CS providers, including in-person sessions, webinars, and/or calls, as necessary, in addition to Network Provider training requirements described in ~~PHC's~~ Partnership's contract with DHCS in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

J. PAYMENT TO COMMUNITY SUPPORTS PROVIDER

1. To the extent possible, ~~PHC~~ Partnership encourages all of its CS providers to submit electronic claims to ~~PHC~~ Partnership for payment.
   a. When a CS provider does not have the ability to submit a claim electronically, ~~PHC~~ Partnership

shall accept an invoice via mail.

1) CS providers shall make a good faith attempt when remitting invoices to ~~PHC~~ Partnership for the purposes of reimbursement of approved CS services to use the necessary billing and member-specific encounter information for DHCS ~~PHC~~ Partnership validation and DHCS reporting purposes.
2) Invoices sent via mail shall be processed in the same time frames as electronic claims.
3) In the event of a request for expedited claim payment, the plan will review the request on a case-by-case basis.
4) For more information on how to submit claims, refer to ~~PHC's~~ Partnership's Provider Manual, Section 3: Claims at http://www.partnershiphp.org/Providers/Policies/Pages/Section3.aspx

K. DHCS COMMUNITY SUPPORTS REPORTING

1. ~~PHC~~ Partnership will submit the following data and reports to DHCS to support DHCS' oversight of CS:
   a. Encounter data
      1) ~~PHC~~ Partnership shall submit all CS encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
      2) ~~PHC~~ Partnership shall be responsible for submitting to DHCS all CS encounter data, including encounter data for CS generated under subcontracting arrangements.
      3) In the event the CS Provider is unable to submit CS encounters to ~~PHC~~ Partnership using the national standard specifications and code sets to be defined by DHCS, ~~PHC~~ Partnership shall be responsible for converting CS Providers' invoice data into the national standard specifications and code sets for submission to DHCS.
   b. Supplemental reporting
      1) Contractor shall submit supplemental reports on a schedule and in a format to be defined by DHCS.
   c. In the event of underperformance by ~~PHC~~ Partnership in relation to its administration of CS, DHCS may administer sanctions as set out in the DHCS Contract Exhibit E, ~~Attachment 2,~~ Provision 1.1.19~~16~~, Sanctions.

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) 438.3(e)(2)
B. DHCS All Plan Letter (APL) 21-017 Community Supports Requirements (*Revised* 03/01/2022)
C. DHCS Contract Exhibit A, Attachment III, ~~5~~ 2.3 Utilization Management; 4.5 Community Supports; ~~Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Composition; Exhibit A, Attachment 7, Provision 5, Network Provider Training~~
D. DHCS Contract Exhibit E, ~~Attachment 2,~~ Provision 1.1.19~~16~~, Sanctions.
E. DHCS Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide (July 2023)
F. CalAIM Data Guidance - Community Supports Member Information Sharing (~~April 2023~~December 2024)
G. DHCS APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements (09/14/2023)

VIII. DISTRIBUTION:

A. ~~PHC~~ Partnership Department Directors
B. ~~PHC~~ Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer Director, Enhanced Health Services

Policy/Procedure Number: MCUP3142			**Lead Department: Health Services** **Business Unit: EHS**
Policy/Procedure Title: CalAIM Community Supports (CS)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/09/2022 Effective Date: 01/01/2022 vs. DHCS		**Next Review Date: 01/10/202502/12/2026** **Last Review Date: 01/10/202402/12/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

X. REVISION DATES: 01/11/23; 06/14/23; 01/10/24; 02/12/25

PREVIOUSLY APPLIED TO: N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by ~~PHC~~ Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual needs and the benefits covered under Partnership~~HC~~.

~~PHC's~~ Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA ~~10/17/2024~~02/12/2025
Community Supports Criteria Matrix and HCPCS Code Chart

See further descriptions of each column header on pages 4 - 6

	Community Support Services	Housing Transition Navigation Services	Housing Deposits	Housing Tenancy and Sustaining Services	Short-Term Post-Hospitalization Housing	Recuperative Care	Meals/ Medically Tailored Meals	Respite Services	Personal Care and Homemaker Services	Day Habilitation Program	Sobering Center
	HCPCS Codes	**H0043, H2016**	**H0044**	**T2041 and TBD**	**H0044**	**T2033**	**S5170; S9470**	**H0045, S5151, S9125**	**S5130, T1019**	**T2014, T2020, H2014**	**H0014**
1	Individuals prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System (CES): Highly vulnerable individuals with disabilities, chronic conditions/mental illness, substance use disorder and upon exiting incarceration ~~(estimated effective in January 2024)~~	X	X	X							
2	Qualifies for HUD definition of Homeless: People who are living in a place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last 3 years (must total 12 months)	X	X	X	X						
3	Qualifies for definition of chronic homelessness: Must have (A) been continuously homeless for the last 12 months OR (B) has a minimum of 4 occasions of homeless over the last 3 years totaling a minimum of 12 months	X	X	X	X						
4	Qualifies for HUD definition of at risk of homelessness: Have an annual income below 30% of median family income for the area, as determined by HUD and, do not have sufficient resources or support networks i.e. family, friends, faith based, social networks, immediately available to prevent them from moving to an emergency shelter	X	X	X	X						
5	Qualifies for at risk of experiencing homelessness: Those who are at risk of homelessness including individuals and families who have an annual income below 30% of median family income of the area as determined by HUD	X	X	X	X						
6	Qualifies for No Place Like Home definition of “at risk of chronic homelessness”	X	X	X	X						
7	Individuals who are not receiving duplicative support from other State, local tax, or Federally funded programs	X	X	X	X	X	X	X	X		
8	Identified as reasonable and necessary in the individual’s housing support plan	X	X	X							
9	Any individual who received Housing Transition/ Navigation Services in counties that offer Community Support Housing Transition/Navigation Services		X	X							
10	May only receive once in individual’s lifetime.		X		X						
11	Only available for a single duration in the individual’s lifetime. Service may be considered for one additional approval with documentation as to what conditions have changed to demonstrate why providing services would be more successful on the second			X							
12	Only available when enrollee is unable to cover deposits required for tenants. The liaison will be responsible for paying deposits to the landlord, PG&E, water deposit, or other utility deposits needed.		X								
13	Individuals must also receive Housing Transition/ Navigation services, at a minimum, the associated tenant screening, housing assessment and individualized housing support plan must be completed in conjunction with this service.		X								
14	Exiting Recuperative Care				X						
15	Individuals exiting an inpatient hospital stay, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility.				X						
17	Individuals who are at risk of hospitalization or are post-hospitalization, requiring mental or medical care and follow up					X					
18	Individuals who live alone with no formal support i.e. services provided by professional trained employees, typically paid for their work.					X					
19	Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.					X					
20	Beneficial to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health or medical interventions.					X					

PARTNERSHIP HEALTHPLAN OF CALIFORNIA ~~10/17/2024~~02/12/2025
Community Supports Criteria Matrix and HCPCS Code Chart

See further descriptions of each column header on pages 4 - 6

	Community Support Services	Housing Transition Navigation Services	Housing Deposits	Housing Tenancy and Sustaining Services	Short-Term Post-Hospitalization Housing	Recuperative Care	Meals/ Medically Tailored Meals	Respite Services	Personal Care and Homemaker Services	Day Habilitation Program	Sobering Center
	HCPCS Codes	H0043, H2016	H0044	T2041 and TBD	H0044	T2033	S5170; S9470	H0045, S5151, S9125	S5130, T1019	T2014, T2020, H2014	H0014
21	Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.							X			
22	Relief of family caregivers of children who previously were covered for Respite Services under the Pediatric Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.							X			
23	Restriction and limitation: Service limit is up to 336 hours of service per year.							X			
24	Individuals at risk for hospitalization, or institutionalization in a nursing facility								X		
25	Individuals with functional deficits and no other adequate support system, such as vision, hearing or movement limitation or growth, behavioral, language development or physical or spiritual development disorders.								X		
26	Individuals approved for In-Home Supportive Services (IHSS)								X		
27	Can be receiving In-Home Supportive Services (IHSS), when additional hours are required or if IHSS benefits are exhausted.								X		
28	Individuals with chronic conditions, such as, but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other ~~high risk~~high-risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.						X				
29	Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement.						X				
30	Individuals with extensive care coordination needs.						X				
31	Limitation = Up to 2 meals per day for up to 12 weeks = longer if determined medically necessary						X				
32	Limitation = meals not covered to respond solely to food insecurities.						X				
33	Cannot be enrolled in any other alternative food program or delivery services.						X				
34	Restriction and limitation: In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hrs per day of care.							X			
35	Restriction and limitation: This service is only to avoid placement to which the medical managed care plan would be responsible.					X		X			
36	Restriction and limitation: Necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral or medical interventions.					X					
37	Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program									X	
38	Individuals ages 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.									-	X
39	Limitation = Service covered for a duration of less than 24 hours										X

Housing Transition/Navigation Services

Eligibility Criteria

- Are prioritized for a permanent supportive housing unit or rental subsidy resource through a local Coordinated Entry System (CES).
- Meet the Housing and Urban Development (HUD) definition of homeless.
- Meet the definition of an individual experiencing chronic homelessness.
- Meet the HUD definition of at risk of homelessness.
- Are determined to be at risk of experiencing homelessness.
- Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness."

Restrictions and Limitations

- Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan.

Housing Deposit

Eligibility Criteria

- Received Housing Transition/Navigation Services Community Supports in counties that offer Housing Transition/Navigation Services.
- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CBO.
- Meet the Housing and Urban Development (HUD) definition of homeless.
- Meet the HUD definition of at risk of homelessness.
- Are determined to be at risk of experiencing homelessness.
- Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness."

Restrictions and Limitations

- Only available in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt.
- Must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.
- Individuals must also receive Housing Transition Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Housing Tenancy & Sustaining Services

Eligibility Criteria

- Received Housing Transition/Navigation Services Community Supports in counties that offer Housing Transition/Navigation Services (but this is not a requirement)
- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CBO.
- Meet the Housing and Urban Development (HUD) definition of homeless
- Meet the definition of an individual experiencing chronic homelessness
- Meet the HUD definition of at risk of homelessness
- Are determined to be at risk of experiencing homelessness
- Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness"

Restrictions and Limitations

- These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed.
- Only available for a single duration in the individual's lifetime. They can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt.
- These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.
- Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

Short-Term Post-Hospitalization Housing

Eligibility Criteria

- Are exiting recuperative care.
- Individuals exiting an inpatient hospital stay residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria.
  - Meet the Housing and Urban Development (HUD) definition of homeless.
  - Meet the definition of an individual experiencing chronic homelessness.
  - Meet the HUD definition of at risk of homelessness.
  - Who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services.
  - Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness."

Restrictions and Limitations

- Only available once in an individual's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.
- The service is only available if enrollee is unable to meet such an expense.

Recuperative Care

Eligibility Criteria

- Individuals who are at risk of hospitalization or are post-hospitalization.
- Individuals who live alone with no formal supports.
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.

Restrictions and Limitations

Recuperative care/medical respite is an allowable Community Supports service if it is:

- Necessary to achieve or maintain medical stability and prevent hospital admission or re- admission, which may require behavioral health interventions.
- Not more than 90 days in continuous duration.
- Does not include funding for building modification or building rehabilitation.

Medically Tailored Meals/ Medically Supported Food

Eligibility Criteria

- Individuals with chronic conditions, such as but not limited to, diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
- Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement.
- Individuals with extensive care coordination needs.

Restrictions and Limitations

- Up to two medically-tailored meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if determined medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Meals are not covered to respond solely to food insecurities.

Respite Services (Effective January 1, 2023)

Eligibility Criteria

- Individuals who live in the community and are compromised in their Activities of Daily Living(ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.
- Other subsets may include children who previously were covered for Respite Services under the Pediatric Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

Restrictions and Limitations

- In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.
- Service limit is up to 336 hours per calendar year.
- This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Personal Care & Homemaker Services (Effective January 1, 2023)

Eligibility Criteria

- Individuals at risk for hospitalization, or institutionalization in a nursing facility.
- Individuals with functional deficits and no other adequate support system.
- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions and Limitations

- This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.
- If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker services during this reassessment waiting period.

Sobering Centers (Effective July 1, 2024)

Eligibility Criteria

- Individuals ages 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms), and who otherwise can be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center

Restrictions and Limitations

- This service is covered for a duration of less than 24 hours.
- This service shall supplement and not supplant services received by the Member through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions (STCs) and federal DHCS guidance.

Day Habilitation Program (Effective January 1, 2025)

Eligibility Criteria

- Individuals experiencing homelessness
- Individuals who exited homelessness and entered housing in the last 24 months
- Individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in day habilitation program

Restrictions and Limitations

- This service shall supplement and not supplant services received by the Member through other State, local, or federally-funded programs, in accordance with the CalAIM ~~Special Terms and Conditions (~~STCs ~~)~~and federal DHCS guidance.

~~**Sobering Centers** (Effective July 1, 2024)~~

~~**Eligibility Criteria**~~

- ~~Individuals ages 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms), and who otherwise can be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center~~

~~**Restrictions and Limitations**~~

- ~~This service is covered for a duration of less than 24 hours~~

- ~~This service shall supplement and not supplant services received by the Member through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal DHCS guidance~~

COMMUNITY SUPPORTS (CS) SERVICES

Authorization for Use, Exchange, and/or Disclosure
of my Confidential Health Care and Personal Information

Purpose
Health care providers, health payers, and social services agencies have joined together to provide **Community Supports (CS) Services** to help promote your health and well-being. To allow Partnership HealthPlan of California ("**Partnership**") and/or other entities to share your health care and other personal information with each other to help provide you with these CS Services, you must give your authorization first. By filling out this form, you are authorizing the use and release of your health care and other personal information by the following entities participating in CS ("**CS Entities**"): health care providers such as hospitals, physicians, and pharmacies; Partnership and other managed care plans that administer Medi-Cal benefits and pay for services you receive under Medi-Cal; community-based organizations that must comply with health care privacy laws; school-based providers such as nurses, social workers, and counselors; the California Departments of Health Care Services, Public Health, Social Services, and Developmental Services; and county agencies including, but not limited to, mental health plans; and providers and case managers at correctional facilities, but only for the purposes set forth below. Your authorization will permit CS Entities to use and release your health care and other personal information for the following purposes ("**Purposes**"): to allow these entities to address your health-related social needs, including housing transition navigation services; housing deposits; short-term post-hospitalization housing; short-term residential care including housing, meals, and ongoing medical monitoring; caregiver services; day habilitation programs; assistance transitioning from a nursing facility to an assisted living facility or private residence; in-home support services; home adaptations or modifications; medically tailored meals; and sobering centers ("**Purposes**"). The information that you authorize for use and release may be shared in a secure electronic format, in writing, or verbally to coordinate CS Services for you.

Member Information	
First Name:	Last Name:
Address:	
Phone Number: ( )	Date of Birth:
Member ID/CIN:	

I authorize and ask that **Partnership HealthPlan of California and participating CS Entities named in Attachment A** to use and share any of my health care or other personal information with each other for the reason stated in this Authorization.

Choose ONE of the following options:

INITIAL HERE	**Consent for communication by CS Program:** By putting my initials here, I am allowing ALL of the CS Entities listed in **Attachment A** to use and share my health care and other personal information about my medical history, physical and mental condition, and receipt of social services, and to communicate with each other in order to provide CS Services. The types of health and other confidential information that I am authorizing between CS Entities include: (a) Protected health information (PHI), including information regarding my health

	care, medical history, lab test results, and current or future conditions and treatment; (b) Mental health information, including current and past diagnoses and treatments of my mental health conditions, excluding psychotherapy notes which are only shared if I sign a separate consent form; (c) Individualized Education Program information and other information about social services provided in school; (d) Medi-Cal eligibility/enrollment information, which includes income and certain other demographic and geographic information pertaining to my eligibility for Services and benefits; (e) Housing/homelessness information, including my housing status, history, and supports; and (f) Limited criminal justice information, including booking data, dates and location of incarceration, and supervision status. My consent does not apply to my criminal history, charges, and immigration status.
INITIAL HERE	**Decline to participate in CS:** I understand that the CS program allows CS Entities to be in contact with each other to coordinate my care. I decline to participate in the CS program. I can ask to participate in case management programs for which I am eligible.

Further, by putting my initials below, I specifically authorize the release of the following information (this information will NOT be released unless you specifically allow it)	
INITIAL HERE	Mental health information, including diagnosis, treatment plan, and provider name. This does not include psychotherapy notes which are only shared if I sign a separate consent form.
INITIAL HERE	HIV Test Results (Health & Safety Code § 120980 (g))

Substance Use Disorder Information

Substance use disorder ("**SUD**") records are protected by federal confidentiality rules (42 CFR Part 2). The federal rules do not allow any further release of information that finds a patient as having or having had a substance use disorder either by reference to publicly available information, or through proof of such identification by another person unless further release is permitted by the written consent of the person whose information is being given or as otherwise permitted by 42 CFR Part 2. The federal rules restrict any use of the information to investigate or prosecute, with regard to a crime, any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. By filling out this section, you are authorizing CS Entities to use and release the following SUD information for the Purposes described in this form: your current and past drug or alcohol use diagnoses, medications, treatment, lab tests, trauma history, facility discharges, and any other SUD information about you that comes from a substance/alcohol use disorder provider subject to federal SUD confidentiality regulations (42 C.F.R. Part 2). SUD records (or information therein) that are used or disclosed for treatment, payment, or health care operations by certain CS Entities, including health care providers, may be redisclosed as permitted in the federal HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. Your SUD counseling notes will not be shared unless you sign a separate consent form.

INITIAL HERE	Initial here to allow the CS Entities in **Attachment A** to use and share your SUD information as described above, excluding SUD counseling notes.

Expiration of Form

Choose ONE of the following options:

INITIAL HERE	**Standard expiration:** This form will expire 1 year from today's date; OR
INITIAL HERE	**Expiration:** This form will expire on:_____. This date may not be less than 6 months (to participate in CS services), but may be more than 1 year from today's date.

I understand that:

- I can revoke this Authorization at any time by calling Partnership at (800) 863-4115 or by sending a signed revocation request to:

  Partnership HealthPlan of California
  Attn: Enhanced Health Services
  4665 Business Center Drive
  Fairfield, CA 94534

- A revocation is effective when received, but may not apply to information already shared, based on my prior consent to use or release information.
- I can choose not to sign this form and doing so will not affect my treatment or care, my eligibility for or ability to receive Services, or the payment for Services. However, my ability to participate in CS Services may be affected by not signing this Authorization.
- Even if I do not sign this form, under federal and state privacy laws, some of the CS Entities may share my confidential information for treatment, payment, and other purposes, but providers subject to federal substance use confidentiality laws generally may not share my substance use disorder information without my consent (42 CFR Part 2).
- The information I authorize for use or release may be re-shared by CS Entities, but only in compliance with this Authorization and applicable law.
- I can get a copy of the health information that is being shared.
- I have the right to ask for a copy of this form and one will be sent to me.
- I may obtain a list of all CS Entities to which my information has been disclosed, including those entities identified in **Attachment A**, by contacting Partnership.
- If I voluntarily include my phone number above, I consent to the receipt of texts or calls to communicate with me about my consent choices and how my health and other confidential information may be shared (standard message and data rates may apply).
- Each of the above rights extend to any representative I authorize under applicable law.

[*signature on next page*]

Signature of Member

If you are signing this Authorization on your own behalf, fill out the first line. If you are signing on behalf of someone else, fill out the second line. If you are signing on behalf of a minor aged 12-17, the minor should fill out the first line and you should fill out the second line.

Beneficiary's Name	Beneficiary's Signature	Date (mm/dd/yyyy)
Representative's Name	Representative's Signature	Date (mm/dd/yyyy)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: ~~MCUP3143~~MCHP3143</td><td colspan="3">Lead Department: Health Services
Business Unit: EHS</td></tr>
<tr><td colspan="3">Policy/Procedure Title: CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 03/09/2022
Effective Date: 01/01/2022 vs. DHCS</td><td colspan="4">Next Review Date: ~~01/10/2025~~02/12/2026
Last Review Date: ~~01/10/2024~~02/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage [1]</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~01/10/2024~~02/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MC~~H~~HP2032 – CalAIM Enhanced Care Management (ECM)
B. MC~~H~~UP3142 – CalAIM Community Supports (CS)
C. MCUP3041 – Treatment Authorization Request (TAR) Review Process
D. MCUP3037 – Appeals of Utilization Management / Pharmacy Decisions
E. CGA024 – Medi-Cal Member Grievance System
F. CMP36 – Delegation Oversight and Monitoring
G. MCUG3011 – Criteria for Home Health Services

II. IMPACTED DEPTS:

A. Health Services
B. Care Coordination
C. Claims
D. Finance
E. Member Services
F. Provider Relations
G. Administration

III. DEFINITIONS:

A. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).
B. Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
C. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules. However, because dual eligible members in D-SNPs are not eligible for Medi-Cal ECM, a separate Partnership Advantage ("PA") policy will be crafted.

and home health care services for in-home visits by a provider. In California, this is known as CalEVV.

IV. ATTACHMENTS:

A. Community Supports Criteria Matrix and Community Supports HCPCS Code Chart
B. Enhanced Care Management HCPCS Code Chart
C. Community Support Services Referral Form

V. PURPOSE:

To describe Partnership HealthPlan of California's PHprocess for reviewing and authorizing requests for the Enhanced Care Management (ECM) benefit and optional Community Supports (CS).

VI. POLICY / PROCEDURE: /

A. ENHANCED CARE MANAGEMENT (ECM)

1. A Treatment Authorization Request (TAR) is required for all members receiving the ECM Benefit.
2. Providers shall submit a TAR to request ECM services electronically or via fax to PHCPartnership's Health Services Department for review. Instructions on how to submit a TAR and PHCPartnership's TAR processing timelines are described in PHCPartnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process.
3. ECM Eligibility Criteria:
   a. Member meets eligibility criteria as outlined in section VI.A. of policy MCHCP2032 CalAIM Enhanced Care Management (ECM).
4. ECM TAR Requirements
   TARs submitted to PHCPartnership for ECM services shall contain:
   a. Documentation of the ECM Population(s) of Focus that the member meets criteria for
   b. Proposed ECM date(s) of services
      1) Dates should include the initial date of outreach and engagement, as well as the length of service anticipated, up to a maximum of 12 months initially
      2) If additional time or service is necessary, a new TAR shall be submitted
      3) Renewal TARs shall be submitted at least 10 days prior to the end of the prior approval to avoid gaps in care.
      4) Reauthorization will be approved up to a maximum of 6 months
   c. Service codes for ECM as outlined in Attachment B, ECM HCPCS Code Chart.
5. ECM providers are responsible for notifying PHCPartnership if a member discontinues ECM services. See PHCPartnership Policy MCCP2032 CalAIM Enhanced Care Management (ECM), section VI.F. Discontinuation of ECM.
6. For information on the process for a member, member's authorized representative, or a provider on behalf of a member, to appeal PHCPartnership UM decisions, see PHCPartnership policy MCUP3037 Appeals of
   Utilization Management/ Pharmacy Decisions.
7. Effective January 1, 2025, in accordance with DHCS requirements, Partnership will allow for ECM presumptive authorization which permits specific ECM providers for designated Populations of Focus to directly authorize the initial ECM service for a timeframe of 30 calendar days.
7.8. Partnership will ensure Members who received pre-release services are automatically eligible to receive ECM for six months under the Justice Involved (JI) Population of Focus on the day of release, or, if Managed Care Plan (MCP) enrollment is effectuated after release, on the day of MCP enrollment with Partnershipday.

B. COMMUNITY SUPPORTS (CS)

1. A Treatment Authorization Request (TAR) is required for all members receiving a CS service.
2. Providers shall submit a TAR to request a CS service electronically or via fax to PHCPartnership's

Health Services Department for review. Instructions on how to submit a TAR and ~~PHC~~Partnership's TAR processing timelines are described in ~~PHC~~Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process.

3. ~~PHC~~Partnership is not required to offer CS services to all members in all of its service areas. To see a list of CS services that ~~PHC~~Partnership currently offers, see section VI.A. of policy MCH~~U~~P3142 CalAIM Community Supports.
4. CS Eligibility Criteria:
   a. To be eligible for a CS service, members must meet the medical necessity criteria outlined for the CS in Attachment A - Community Supports Criteria Matrix and Community Supports HCPCS Code Chart.
   b. ~~PHC~~Partnership shall review all CS TARs on an individual basis to ensure the services requested are appropriate and cost-effective as outlined in DHCS APL 21-017 *Revised* Community Supports Requirements.
5. CS TAR Requirements:
   a. TARs submitted to ~~PHC~~Partnership for a CS service shall contain:
      1) A Community Support Services Referral Form (Attachment C)
      2) Documentation of the medical necessity criteria as outlined in Attachment A.
         a) Depending on the type of CS service(s) requested, additional documentation may be required such as Housing Supportive Plan, Contract and/or Legal Agreement between the landlord and individual, etc.
      3) Proposed date(s) of service
      4) Service codes for the CS service as outlined in Attachment A.
      5) In the event Partnership identifies the CS service authorization has an inappropriate, inequitable, and/or discriminatory effect, Partnership will take immediate action and set a Corrective Action Plan (CAP), one-on-one meetings, and/or follow-ups guarantee CS services providers and/or delegates adhere and align to Partnership's policies and procedures
         a) If a provider fails to adhere to the CAP, it may be decided to terminate the provider's contract.
6. Electronic Visit Verification (EVV) Requirements:
   Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal personal care services and home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
   a. Providers of Community Supports (including Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs) must complete a self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator no later than October 19, 2022.
   b. Please refer to policy MCUG3011 Home Health Services for further information on EVV requirements.
7. For information on the process for a member, member's authorized representative, or a provider on behalf of a member, to appeal ~~PHC~~Partnership UM decisions, see ~~PHC~~Partnership policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.

C. MEMBERS TRANSITIONING FROM ANOTHER MANAGED CARE PLAN (MCP)
1. Members transitioning to ~~PHC~~Partnership from another managed care plan and/or fee-for-service Medi-Cal who are currently receiving ECM and/or CS, shall automatically be authorized for ECM and/or CS.
   a. ECM and/or CS providers are not required to submit a TAR to ~~PHC~~Partnership for transitioning members. For these members, ~~PHC~~Partnership shall enter a presumptive TAR on the provider's behalf.

b. All TARs submitted after the presumptive TAR must contain the documents required for the services above.
c. All members continuing ECM and/or CS services must meet criteria as outlined in MCHCP2032 CalAIM Enhanced Care Management (ECM) and/or MCHUP3142 CalAIM Community Supports (CS)

2. Beginning January 1, 2024, members receiving ECM and/or CS services who are enrolled in the expansion counties transitioning to PHCPartnership will automatically be authorized for ECM and/or CS services, for these members:
   a. Under the Continuity of Care for Providers requirement, members may continue to see their out-of-network ECM provider who they have a pre-existing relationship with for up to 12 months. PHCPartnership will not require a TAR for transitioning members. For these members, PHCPartnership shall enter a presumptive TAR for 12 months.
   b. ECM providers are not required to submit a TAR to PHCPartnership for transitioning members. For these members, PHCPartnership shall enter a presumptive TAR for six (6) months.
   c. CS providers are not required to submit a TAR to PHCPartnership for transitioning members. For these members, PHCPartnership shall enter a presumptive TAR for six (6) months on the provider's behalf.
   d. All TARs submitted after the presumptive TAR must contain the documents required for the services above.
   e. All members continuing ECM and/or CS services must meet criteria as outlined in MCHCP2032 CalAIM Enhanced Care Management (ECM) and/or MCHUP3142 CalAIM Community Supports (CS)

D. WHOLE PERSON CARE TRANSITION TO ECM OR CS
1. Beginning January 1, 2022, PHCPartnership shall automatically authorize ECM and/or CS services for member who are identified by the Whole Person Care Lead Entity as eligible and transitioning from a Whole Person Care Pilot.
2. ECM and CS provider are not required to submit a TAR to PHCPartnership for transitioning members. For these members, PHCPartnership shall enter a presumptive TAR for six (6) months on the provider's behalf.
3. ECM and CS providers shall submit to PHCPartnership a renewal TAR ten (10) days prior to the expiration of the presumptive TAR to avoid gaps in care for the member.
   a. All TARs submitted after the presumptive TAR must contain the documents required for services above.
   b. All members continuing ECM and/or CS services must meet the benefit criteria as outlined in MCCP2032 CalAIM Enhanced Care Management (ECM) and/or MCUP3142 CalAIM Community Supports (CS).

E. QUALITY MONITORING
1. PHCPartnership shall review all ECM and CS TARs in an equitable and non-discriminatory manner.
2. During the review process, PHCPartnership shall screen members for ECM and/or CS services and make referrals for additional services when appropriate.
3. PHCPartnership shall actively monitor and track utilization and quality of the ECM benefit and approved CS services. For details on PHCPartnership's activities for oversight and quality monitoring, see PHCPartnership policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCUP3142 CalAIM Community Supports (CS).

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) 438.3(e)(2)
B. DHCS CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Contract
C. DHCS Contract Exhibit A, Attachment 5 Utilization ~~Management and~~Management and Attachment 6,

Provision 13, Ethnic and Cultural Composition

D. DHCS Contract Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals
E. DHCS APL 23-032 Enhanced Care Management Requirements (~~09/15/2021~~12/22/2023)
F. DHCS APL 21-017 *Revised* Community Supports Requirements (03/01/2022)
G. DHCS APL 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)
H. DHCS CalAIM ECM Policy Guide (~~September~~ August ~~2024~~32024)
I. DHCS Medi-Cal CalAIM Community Supports, or In Lieu of Services (ILOS), Policy Guide (July 2023)
J. DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide (~~09/29/2023~~03/22/2024)

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: ~~Chief Health Services Officer; Director of Utilization Management Strategies~~Chief Health Services Officer; Director of Enhanced Health Services

X. REVISION DATES: 01/11/23; 06/14/23; 01/10/24; 02/12/25

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by ~~PHC~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3034 (previously UG100334)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: PCP-To-PCP Transfers & Assignments of New Members to PCP</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 08/09/1995</td><td colspan="4">Next Review Date: ~~03/13/2025~~02/12/2026
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~03/13/2024~~02/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3039 - Direct Members
B. MCCP2014 – Continuity of Care
~~C.~~ MCCP2024 – Whole Child Model for California Children's Services (CCS)
~~D.~~C. ~~MPCP2002 - California Children's Services~~

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Medical Home: The provider identified as the ~~member~~Member's medical home or primary care provider (PCP) is responsible for managing the ~~member~~Member's primary care needs.
C. Whole Child Model (WCM): ~~In participating counties, T~~this program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for Partnership HealthPlan of California ~~(PHC)~~ pediatric ~~member~~Members with a CCS-eligible condition(s).

IV. ATTACHMENTS:

APPENDIX
A. Guidelines for Determining Medical Stability Prior to PCP Transfer

V. PURPOSE:

To clarify when transfers are medically acceptable.

VI. POLICY / PROCEDURE:

A. Primary Care Provider (PCP) to PCP transfers:
   1. At the time a ~~member~~Member requests transfer from one PCP to another, the ~~member~~Member must be medically stable in order for the transfer to be processed by the Member Services Department. See Appendix A.
   2. A ~~member~~Member who is "unstable" is not to be transferred from one PCP to another without the approval of both the current and accepting PCPs. Unstable means that the ~~member~~Member possesses one or more medical conditions such that transfer at that point in time might jeopardize the

care of that ~~member~~Member.

3. A ~~member~~Member with a pre-existing medical condition(s) who is not unstable is eligible for PCP transfer when requested by the ~~member~~Member.
4. Pregnant ~~member~~Members are permitted to change PCP assignment through week 32 of pregnancy, but are considered inappropriate for transfer from the 33rd week of pregnancy until 8 weeks postpartum. Exceptions for ~~member~~Members wishing to transfer after 32 weeks of pregnancy and before 8 weeks postpartum are permitted with the approval of the potential accepting PCPs.
5. If Partnership HealthPlan of California (~~PHC~~Partnership) determines that a ~~member~~Member is eligible for Direct Member status at the time of the requested PCP transfer, an assignment to a Direct Member category is made, rather than assignment to a PCP.
6. When a ~~member~~Member requests a transfer from one PCP to another, the Member Services Department at ~~PHC~~Partnership is to screen the request for suitability of transfer. Information regarding the ~~member~~Member's medical condition(s) and stability are assessed. When necessary, the HealthPlan's Chief Medical Officer or physician designee determines the ~~member~~Member's suitability and timing for transfer.

B. Assignment of new ~~member~~Members to a PCP

1. A new ~~member~~Member who indicates preference for a particular PCP is assigned to that provider if the provider is accepting new ~~member~~Members.
2. A ~~member~~Member who does not submit a choice of PCP within the specified time frame is randomly auto-assigned to a PCP from the geographic pool of PCPs who are accepting new ~~member~~Members through this process.
3. If ~~PHC~~Partnership determines that a ~~member~~Member is eligible for Direct Member status, an assignment to a Direct Member category is made.
4. If a ~~member~~Member is at least 28 weeks pregnant when they become a ~~PHC~~Partnership ~~member~~Member, they will be granted Direct Member status for continuity of care. The Direct Member status is closed the 1st of the month following 8 weeks postpartum.
5. In all cases, it is expected that the PCP accepting new ~~PHC~~Partnership ~~member~~Members (by ~~member~~Member choice or by auto-assignment) will assume responsibility for the ~~member~~Member, even if the ~~member~~Member currently is hospitalized, is in active care, or has a pre-existing medical condition. If ~~PHC~~Partnership determines that a hospitalized new ~~member~~Member will become capitated to a hospital on the first of the next month and may still be hospitalized at that time, ~~PHC~~Partnership will notify the capitated hospital and the PCP of the impending assignment.
6. A ~~member~~Member with a CCS-eligible condition who indicates a preference for a particular medical home, is assigned to that provider if the provider is accepting new ~~member~~Members. The provider identified as the child's medical home is responsible for managing the child's primary care needs and coordinating the child's care for both the CCS-eligible condition(s) and the non-CCS-eligible condition(s). CCS/ WCM children do not require a Referral Authorization Form (RAF) to see a specialist for either the CCS-eligible condition(s) or the non-CCS eligible condition(s)~~[1]~~.

VII. REFERENCES:

N/A

~~[1] For Members under age 21 with a CCS-eligible condition, services for the CCS-eligible condition will either be authorized by PHCPartnership under the Whole Child Model program, or by the State CCS program (*see policy MPCP2002 California Children's Services)*. In PHCPartnership's service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in PHCPartnership's service area are participants in the State's CCS program and are not participants in PHCPartnership's Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.~~

Policy/Procedure Number: MCUP3034 (previously UG100334)		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: PCP-To-PCP Transfers & Assignments of New Members to PCP		☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/09/1995	**Next Review Date: 03/13/202502/12/2026** **Last Review Date: 03/13/202402/12/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VIII. DISTRIBUTION:
A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 10/13/99; 03/21/01; 04/17/02; 08/20/03; 10/19/05; 10/18/06; 09/19/07; 10/15/08; 01/18/12; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 11/13/19; 10/14/20; 02/10/21; 02/09/22; 01/11/23; 03/13/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by ~~PHC~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

APPENDIX A

Guidelines for Determining Medical Stability Prior to PCP Transfer

The following groups are considered unstable for purposes of transfer to another Primary Care Provider (PCP).
1. Hospitalized ~~member~~Members or ~~member~~Members discharged from hospital less than 2 weeks prior to request
2. Pregnant ~~member~~Members more than 28 weeks gestation or within 8 weeks after delivery
3. Members scheduled for major therapeutic procedures such as surgery within the next sixty (60) days

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPUP3129			**Lead Department: Health Services** **Business Unit: Utilization Management**	
Policy/Procedure Title: Podiatry Services			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 02/18/2015 **Effective Date:** 02/01/2015		**Next Review Date:** ~~02/14/2025~~02/12/2026 **Last Review Date:** ~~02/14/2024~~02/12/2025		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~02/14/2024~~02/12/2025	

I RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUG3007 – Authorization of Ambulatory Procedures and Services
D. MCUP3013 – Durable Medical Equipment (DME) Authorization
E. MCUG3024 – Inpatient Utilization Management
F. MCUG3032 – Orthotic and Prosthetic Appliances Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Podiatry or podiatric medicine is a branch of medicine devoted to the study of diagnosis, medical and surgical treatment of disorders of the foot, ankle and lower extremity.
B. A Doctor of Podiatric Medicine (DPM) is a medical specialist who diagnoses and treats conditions affecting the foot, ankle, and structures of the leg.
~~C. Full scope PHC members are Members who qualify for a full benefit package without restrictions.~~
~~D.~~C. Podiatry Services include:
   1. Any medical services provided by a DPM, or
   2. Services provided by another physician or non-physician medical practitioner that could be performed by a DPM

~~E.~~D. Direct Members: are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status may be based on the ~~member~~Member's medical condition, prime insurance, demographics or administrative eligibility status. Direct Members do not require a Referral Authorization Form (RAF) to see a specialist.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

This policy defines the scope of podiatric services covered by Partnership HealthPlan of California ~~(PHC), as well as~~ and the process for ~~member~~Members to obtain services.

Policy/Procedure Number: MPUP3129		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Podiatry Services		☒**External Policy** ☐**Internal Policy**
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Applies to:	☒ **Medi-Cal**	☐ **Employees**

VI. POLICY / PROCEDURE:

A. ~~Effective February 1, 2015, medically necessary Podiatry Services~~Podiatric office visits are ~~are~~ covered as medically necessary and are limited to diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot. ~~by PHC for all full-scope PHC members. This includes podiatry services performed in any setting, podiatry services provided by a DPM or any other licensed physician or non-physician medical practitioner.~~

B. Authorization

1. Members assigned to a primary care provider (PCP) must have a Referral Authorization Form (RAF) from their PCP unless the podiatrist is in the same practice.
2. Direct Members may be seen by a Medi-Cal certified podiatrist without a referral.
3. A Treatment Authorization Request (TAR) is required for procedures listed in the ~~PHC~~Partnership TAR Requirements document (see Attachment A of policy MCUP3041 Treatment Authorization Request (TAR) Review Process).
   a. ~~PHC~~Partnership uses InterQual® Procedural Criteria, Adult and Pediatric, to evaluate for appropriate use of procedures and ~~PHC~~Partnership utilization management guidelines to evaluate for durable medical equipment (DME) needs (see policy MCUP3013 Durable Medical Equipment (DME) Authorization).

~~3.~~4. A TAR is not required for office visits.

B. Other Coverage: If a ~~PHC~~Partnership ~~member~~Member has other health coverage (including Medicare) that includes Podiatry Services, the other health insurance or Medicare is the primary payer.

C. Medical necessity: Medical necessity for podiatry services provided to ~~PHC~~Partnership ~~member~~Members will be determined using InterQual~~®~~ criteria, Medi-Cal Guidelines and/or Medicare guidelines.

VII. REFERENCES:

A. Medicare Podiatry Services: Information for Medicare Fee-for-Service Health Professionals. U.S. Department of Health and Human Services. Center for Medicare & Medicaid Services. Medicare Learning Network.

B. InterQual® criteria

C. Medi-Cal Provider Manual/ Guidelines: Podiatry Services (*podi*)

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Provider Manual

B. ~~PHC~~Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: ~~Senior Director,~~Chief Health Services Officer

X. REVISION DATES:

Medi-Cal

03/16/16; 03/15/17; *06/13/18; 06/12/19; 06/10/20; 02/10/21; 02/09/22; 02/08/23; 02/14/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Policy/Procedure Number: MPUP3129		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Podiatry Services		☒**External Policy** ☐**Internal Policy**
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Applies to:	☒ **Medi-Cal**	☐ **Employees**

Healthy Kids MPUP3129 Healthy Kids program ended 12/01/2016
03/16/16 to 12/01/2016

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by ~~PHC~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: CGA024</td><td colspan="3">Lead Department: Administration
Business Unit: Grievance & Appeals</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Medi-Cal Member Grievance System</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/11/99 (MS 300)</td><td colspan="4">Next Review Date: ~~02/14/2025~~02/12/2026
Last Review Date: ~~02/14/2024~~02/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐~~☒~~ Partnership Advantage [1]</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~02/14/2024~~02/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCND9002 Cultural & Linguistic Program Description
B. MPQP1016 Potential Quality Issue Investigation and Resolution
C. MCUP3037 Appeals of Utilization Management/Pharmacy Decisions
D. MPQP1022 Site Review Requirements and Guidelines
E. CGA022 Member Discrimination Grievance Procedure

II. IMPACTED DEPTS:

A. Member Services
B. Provider Relations
C. Health Services

III. DEFINITIONS:

A. Acknowledgment Letter is a written notification of receipt of a grievance or appeal that is sent to the member or the member's authorized representative.
B. Adverse Benefit Determination encompasses all previously existing elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determination involving medical necessity, appropriateness, setting, covered benefits, and/or financial liability. An adverse benefit determination is defined to mean any of the following actions taken by a Managed Care Plan (MCP) (i.e., Partnership HealthPlan of California (Partnership)):
   1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
   2. The reduction, suspension, or termination of a previously authorized service.
   3. The denial, in whole or in part, of payment for a service.
   4. The failure to provide services in a timely manner.
   5. The failure to act within the required timeframes for standard resolution of grievances and appeals.
   6. The denial of the member's request to obtain services outside thenetwork.
   7. The denial of a member's request to dispute financial liability.
C. Appeal is a member's request to Partnership for reconsideration of an adverse benefit determination resulting in the delay, modification, or denial of a service, benefit or claim based on medical necessity, or a determination that the requested service was not a covered benefit.
D. Authorized Representative is a relative, friend, attorney or other person authorized by the member to represent them in matters regarding their healthcare.

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules.

E. Complaint is the same as a grievance. See grievance definition.

F. Deemed Exhaustion occurs if Partnership fails to adhere to the state and federal notice and timeframe requirements for either a Notice of Action (NOA) or a Notice of Appeal Resolution (NAR), including failure to provide a fully translated notice, or failure to provide timely and/or sufficient notice in the member's alternative format preferences. When deemed exhaustion occurs, the member may bypass Partnership's internal appeal process and initiate a state hearing.

G. Disputed Services means covered services that are the subject of a pending appeal or state hearing due to an adverse benefit determination by Partnership, or its subcontractors, to terminate, suspend, or reduce previously authorized covered services.

H. Expedited Review is the process by which a decision is rendered when a grievance involves an imminent and serious threat to the health of the member, including, but not limited to: severe pain, potential loss of life, limb or major bodily function. Expedited reviews are approved by physician reviewers. An expedited review is also acknowledged verbally, whenever possible.

I. Grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination.
   1. Exempt Grievance is a grievance that is resolved by the end of the following business day. These grievances are handled by the Member Services Representatives or Grievance staff and are received over the telephone. These grievances are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment.
   2. Standard Grievance is a grievance that cannot be resolved by the end of the following business day. These grievances are handled by the designated Grievance staff.
   3. ~~Second Level Grievance is an appeal of a grievance that has been denied.~~

J. Grievance Nurse Specialist (GNS) is the clinical staff member responsible for initiating and coordinating a multi-disciplinary team approach to handling of grievances with members, providers, plan Medical Directors, departmental directors and managers and others to evaluate, monitor and assure that medically necessary services are provided in a quality, efficient and timely manner. Clinical support is provided to non-clinical staff as needed. The GNS may also provide input or participate in state hearings.

K. Grievance Case Analyst (GCA) is the staff member who is responsible for summarizing, analyzing, investigating and issuing acknowledgments and resolutions to member grievances and appeals. The GCA also represents Partnership during state hearings.

L. Grievance system is the computer system that Partnership uses to log and track member grievances, appeals,and state hearing requests, which are logged by specific grievance types.

M. Inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to; questions pertaining to eligibility, benefits, or other Partnership processes. Where Partnership is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

N. Member is the Medi-Cal eligible individual receiving health care through Partnership to whom reference willbe made as "member" in all protocols.

O. Member Grievance Review Committee (MGRC) is a forum to conduct multidisciplinary review of member grievances (grievances and all level appeals). The committee is made up of representatives from Grievance & Appeals, Member Services, Provider Relations, Care Coordination, Quality Improvement, Utilization Management, and Compliance.

P. Member Services Representatives (MSRs) are the Partnership staff members who assist members or their authorized representatives in learning about and understanding the services and benefits offered through Partnership, including the grievance, appeal and state hearing procedures, and assist members in obtaining resolution to their issues.

Q. Non-Contracting Provider or Practitioner is a health care provider who does not have a contract with Partnership, but may do business with Partnership for specific reasons, e.g., provision of emergency, out-of-state area or one-time member care.

R. Notice of Action is a formal letter informing a member of an adverse benefit determination.
S. Practitioner is a licensed individual who provides medical care.
T. Primary Care Provider (PCP) is a physician who has executed an agreement with Partnership to provide theservices of a primary care physician.
U. Provider is an organization such as a hospital, residential treatment center or rehabilitation facility.
V. Resolution Letter is written notice of the outcome of a grievance or an appeal. This letter will include information regarding any applicable next steps and appeal rights.
W. State Hearing is an appeal filed with the California Department of Social Services. The case is presented to an Administrative Law Judge (ALJ).

IV. ATTACHMENTS:

A. Your Rights Under Medi-Cal Managed Care Letter
B. Member Grievance Form

V. PURPOSE:

To ensure the thorough, appropriate, and timely resolution to member grievances, appeals, and state hearing requests as well as to ensure Partnership's responsiveness to issues raised by Partnership members. The sections below outline the various components to the Grievance System as well as the process for each type of grievance. This policy is written in accordance with Partnership's contract with the Department of Health Care Services (DHCS) Exhibit A, Attachment 13, 14, All Plan Letter 21-011, Title 28 §1300.68 [except Subdivision
§1300.68(c) g) and (h)], §1300.68.01[except Subdivision §1300.68.01(b) and (c)], Title 22 §53858, 42 CFR 438.420(a)(b) and (c) and 42 CFR 438.406(b)(3).

VI. POLICY/PROCEDURE:

A. Member Rights

Partnership takes member grievances, appeals and state hearings seriously and strives to reach a fair resolutionafter a thorough evaluation of each issue. Partnership will address all grievances, appeals and state hearings in a timely and efficient manner and ensure that members are given reasonable opportunity to present evidence, facts, and laws in supportof their grievance. This evidence can be provided in writing, in person, or by telephone. Members have the right to file a grievance or appeal regarding Partnership services. Our benefits and services are described in Partnership's Member Handbook, and include but are not limited to, the following:

1. Medical Services
2. Durable Medical Equipment (DME)
3. Vision Services
4. Transportation
5. Enhanced Care Management (ECM)
6. Community Supports (CS)

The objectives of the grievance resolution process are as follows:

1. To protect the rights of members.
2. To ensure that there is no discrimination by Partnership against a member on the grounds that the memberfiled a grievance, appeal or state hearing.
3. To provide orderly and prompt responses.
4. To assist members in accessing medically necessary care on a timely basis.
5. To facilitate the investigation and resolution of medically related issues by the Medical Director and Health Services staff.

6. ~~Any member whose grievance is resolved or unresolved has the right to request a state hearing.~~ Submissions of a grievance are not ~~constructed~~ construed as a waiver of the member's right to request a statehearing related to an adverse benefit determination.
7. To report and evaluate aggregate data on member grievances to determine areas requiring corrective action and/or opportunities for improvement. To develop and implement necessary corrective actions with the intent of achieving increased member satisfaction.
8. To ensure that all members have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to; translation of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.
9. Ensure members are advised of their rights to submit evidence, facts and law in support of their grievance and are given 10 calendar days to submit the documentation.

B. Cultural and Linguistic Requirements
1. At any point during the grievance process, a member has the right to language translation, including for all Partnership threshold languages and other non-English languages consistent with Partnership policy MCND9002 Cultural & Linguistic Program Description. This includes standard documents and correspondence. The procedure for review of member grievances ensures that all grievances are reviewed by GCAs for any cultural and linguistic issues. Training is provided on a yearly basis.
   a. Consistent with APL 21-004, Partnership advises members of its nondiscrimination policy and availability of language assistance services by providing detailed enclosures with all grievances and appeals related member notices. The Nondiscrimination Notice is also available, upon request, in all threshold languages.
   b. Consistent with APL 22-002, Partnership will provide appropriate auxiliary aids and services to members with disabilities, including alternative formats, upon requests.

C. How grievance processes are communicated to Partnership members
Members will be advised of their rights and access to grievance processes by the following means:
1. Written Materials – The Partnership member grievance process explaining how to file a grievance isprinted in the Partnership Evidence of Coverage/Disclosure Form. It is included in the Partnership MemberNewsletter at least once each year, mailed with all grievance and appeal acknowledgment andresolution letters and on notifications of all treatment authorization request (TAR) denials.
2. Oral Communication – Telephone calls with Partnership staff and Partnership providers and/or practitioners.
3. Contracting Provider – Member grievance forms and a description of the grievance process is available at each contracting provider's office.
4. Partnership Website – Partnership maintains a website on the internet, which provides member grievance forms and information to members on how to file a grievance with Partnership and the expedited medical reviewprocess.
5. Items 1, 3 & 4 above all include the toll-free phone number, internet address, physical addresses, and the toll-free phone number for the hearing and speech impaired for Partnership.

D. Member Grievance Process
Grievances may be filed at any time following any incident or action that is the subject of the member's dissatisfaction. Grievances may address, but are not limited to, the following issues:
1. Difficulty obtaining an appointment
2. Customer service at the provider or practitioner office
3. Billing issues
4. Appointment waiting times
5. Facility conditions
6. Confidentiality issues
7. Refusals of PCP to refer the member for care

E. Grievances Filed

Members can receive assistance in filing a grievance or appeal from a patient advocate, a provider filing on behalf of the member, an ombudsperson or any other persons chosen by the member. There are five (5) methods members or a member's authorized representative may use to file a grievance:

1. By Telephone
   The member can contact Partnership's Member Services department to file a verbal grievance. Partnership usesboth bilingual staff and interpreter services for members who speak other languages (in accordancewith Title 22 CCR 53858). An MSR will record the grievance into Partnership's grievance system.
2. In Writing
   The member may also submit their grievance in writing to Partnership. Upon request, members can request a member grievance form from Partnership or from a contracted provider office. The member grievance form contains information regarding the Partnership member grievance system. ~~as well as a~~Anauthorized representative form is available upon request.
3. In Person
   Members may also visit Partnership's offices in Eureka, Fairfield, and Redding ~~and~~to request an in-person meeting with an MSR to express their grievance in person. Members can also request assistance in filing a grievance from the MSR or Grievance staff. If the member is under the age of 18, a parent or
   guardian may file a grievance on their behalf. Members may also fill out an Authorized Representative Form to authorize someone of their choice to represent them.
4. Contracted Provider
   Members may file a grievance at one of Partnership's contracting providers' offices. The form titled "Member Grievance Form" is available at all contracted provider offices (in accordance with Title22 CCR 53858).
5. Partnership website
   Members can file a grievance by visiting Partnership's website at: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Complaint,-Appeal-and-Hearing.aspxh and select "Online Grievance Form" to file their grievance electronically through Partnership's secure server. Members can contact Member Services for help navigating the website.

F. Delegation

1. Partnership delegates the grievance process, or portions thereof, to ~~Kaiser Health Plan and~~ Carelon Behavioral Health with the exception of Substance Use Disorder (SUD) related grievances pertaining to the Drug Medi-Cal Organized Delivery System (DMC-ODS).
2. Partnership oversees the delegation of the grievance process conducted by these entities through quarterlyreviews of the grievance logs and annual audits.
3. Partnership requires corrective action plans whenever Partnership designated staff identifies a problem in any ofthese ~~entities process~~entity's processes and assigns a deadline for receiving evidence that the problem has been resolved.
4. Partnership provides our Grievance & Appeal policies and procedures to subcontractors/delegates and downstream subcontractors/delegates at the time that they enter into a subcontractor agreement. The policy is available via Partnership's Provider Manual, which is accessible via our external website, https://www.partnershiphp.org.

G. Resolving Member Grievances

The steps to resolve a member's grievance will occur as outlined below, which is established by the date Partnership receives the grievance.

1. The following documents are sent to the member by the grievance staff within five (5) calendar days of receipt of the member's grievance:
   a. Acknowledgment Letter- acknowledges the date the grievance was received and the name,

address and phone number of the GCA who may be contacted about the grievance or the appeal and the toll-free phone number for hearing and speech impaired members.

2. The GCA will conduct a preliminary investigation by contacting medical staff, Partnership's medical staff or other appropriate individuals to gather information.
   a. If the grievance is about quality of care, diagnosis or treatment, or other medical quality issues, the GCA will consult with the GNS.
   b. As noted in section I and J, below, the GNS classifies each grievance as clinical or non-clinical. The GNS works with the GCA to address all clinical issues identified in this grievance process. If a grievance is identified as containing both an appeal of a benefit denial and another grievance issue, each of these will be addressed separately, as noted below.
   c. Quality of Care Grievances: The GNS reviews all grievances for potential quality of care issues. If a potential quality of care issue is suspected, the GNS forwards the grievance with supporting documentation to the Chief Medical Officer (CMO) or physician designee for secondary review. If the CMO or physician designee confirms a potential quality issue (PQI), the case is referred to the Patient Safety team within the Partnership Quality Improvement (QI) department for further investigation as described in MPQP1016 Potential Quality Issue Investigation and Resolution. If the physician does not believe a PQI referral is warranted, but the GNS disagrees, the GNS may nonetheless make a PQI referral to the QI department. Quality of care grievances that are found to be without merit by the GNS and the Medical Director are tracked, but not referred to the QI department for further investigation and action.
   d. Other clinical issues identified by the GNS may include access issues, quality of service issues (includinged alleged discrimination), and quality of facility issues. As the GNS and GCA review incoming grievances, they may determine that the grievance is unfounded, or non-specific and not actionable, and thus not appropriate for referral to another department for investigation. If the non-quality of care grievance requires further investigation, it may be referred to a department within Partnership. Common referrals to other Partnership departments include:
      1) Provider Relations department to address some access issues (for example phone access and waiting room access) and quality of service issues (for example, staff rudeness or clinician miscommunication) with the individual provider or institution. In general, if sufficient and specific information is received in the grievance, such grievances are shared with the management of a site and a response is requested, including self-identified corrective actions if applicable. If the response is judged to be insufficient by the Grievance or Provider Relations staff, the case may be referred to the CMO or physician designee for immediate review.
      2) Care Coordination department to address access issues, such as finding a specialist or getting in to see their assigned PCP. According to Care Coordination policy and the judgement of the Care Coordination nurses and managers, such cases may be escalated to department directors or a Partnership Medical Director if the resolution of the grievance is not possible through normal interventions by Care Coordination staff and the member's health is at risk from this lack of resolution of the care coordination issue.
      ~~3)~~ ~~The QI~~ QI's Member Safety-Quality Inspections Team to evaluate~~s~~ facility quality and safety through the Facility Site Review process. The severity and scope of issues are assessed to decide on appropriate follow-up actions.~~Member Safety team within the QI department for quality of facility complaints (for example waiting room cleanliness). Depending on the nature of the grievance, the patient safety team may perform a spot check of the facility or ask provider relations to perform a spot check of a facility. If an issue is confirmed, it is addressed as a finding in the context of the site review policy MPQP1022 Site Review Requirements and Guidelines.~~

4) ~~Health Education staff within the~~ ~~Population~~ Health Equity department for accusations of discrimination, lack of translation, or cultural incompatibility. This procedure is described in policy CGA022.
5) Member Services department management for problems with the initial member services response to grievances.
6) Compliance department for alleged Health Insurance and Portability and Accountability Act (HIPAA) violations or alleged fraud, waste or abuse.
7) Partnership leadership for Partnership process issues identified.

e. Exempt and standard grievances are recorded and documented in the case management system (Everest).
f. Partnership receives grievances whe~~re~~n a member is dissatisfied about non-covered services. For grievances involving a decision where the requested service is not a covered benefit, the member is offered the right to file an appeal. The resolution will specify the policy or Evidence of Coverage (EOC) that excludes the service. The resolution letter will identify the document and page number where the provision is found. The resolution letter will direct the member to the applicable section of the EOC containing the provision or provide a copy, if requested, of the applicable policy. The resolution letter will explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested by the member.

H. Expedited Grievance Process
If a member or a treating physician requests an expedited review or if the MSR or other Partnership staff determines expedited review is needed, the issue will be immediately forwarded to Partnership's Medical Directors to render a determination as to whether an expedited review is appropriate. For expedited grievances regarding denial of a request for expedited resolution of an appeal, the Medical Director reviewing the expedited request must have the clinical expertise in treating the member's condition or disease. Resolutions onexpedited reviews include an oral and written notification. The process is as follows:
1. Presentation of Evidence, Facts and Law in Support of Member's Grievance
Members are advised of their rights to submit evidence, facts and law in support of their grievance. Members are also informed by the GCA of the limited time available to present evidence due to the nature of the expedited review request.
2. Expedited Review/Grievance Request Approved
If Partnership's Medical Director determines that the grievance involves an imminent and serious threat tothe health of the member, including, but not limited to: severe pain, potential loss of life, limb or major bodily function, the grievance will be handled as an expedited grievance. Grievance staff willnotify members verbally that their request for an expedited review has been approved and their casewill be processed within 72 hours.
3. Expedited Request Denied
If Partnership's Medical Director determines the expedited review process is not necessary, the regular grievance process is followed. Members will be notified verbally by Grievance staff that their requestfor an expedited review has been denied within 72 hours of their request and the grievance will be processed using standard timeframe (30 calendar days).

I. Incoming Grievances
1. When a grievance is received into the Grievance unit, the Grievance Associate (GA) or designee will assign the grievance to a GCA using the Grievance Rotation Tracker.
2. Upon assigning the case, an email is generated to all Grievance staff, including the GNS. The GNS will log into the grievance system to evaluate if the case is a clinical or non-clinical grievance. An assessment note will be placed in the grievance system under the "Case Confirmed-Clinical" ~~vs~~ or "Case Confirmed--Non-Clinical" action by the GNS. Grievance staff will ~~utilize the grievance categories worksheet to~~ assess the grievance for other referrals to Partnership departments ~~and will proceed as directed in the worksheet~~.

3. All clinical cases are reviewed by the GNS or designee to evaluate the need to forward the case to the QI department for a PQI and/or order records for further evaluation. The GNS or designee will direct Grievance staff if a PQI referral is needed. The GNS or designee will also make recommendations for casework on any clinical cases.

J. Clinical Grievance

A clinical grievance is defined as any issue concerning the member experience provided by a clinic, hospital, or provider. The types of grievances considered to be clinical in nature include:

1. Quality of Service (by clinic/hospital/provider)
2. Access
3. Quality of Medical Care
4. Denials, Refusals (denial of service/treatment) by provider, and not by Partnership
5. Cultural, Linguistic, and Health Education (by clinic/hospital/provider)
6. Transportation Related Grievances

K. Non-Clinical Grievance

A non-clinical grievance is defined as any issue concerning the services provided by Partnership and its non-clinical components. The types of grievances considered to be non-clinical in nature include:

1. Billing
2. Benefits/Coverage
3. Cultural, Linguistic, and Health Education (by Partnership staff, Partnership materials)
4. Quality of Service (by Partnership staff)
5. Enrollment (cancellation of coverage, premium increase, denial of enrollment)
6. Transportation Related Grievances

L. Quality of Medical Care Grievances

1. All quality of medical care grievances are reviewed by Partnership clinical staff to assess the member's concern for accuracy. For example, it is not unusual for a patient to feel their treatment was incorrect, when in fact it was correct (medical records show that the treatment plan prescribed by theprovider is clinically sound).
2. The designated Partnership clinical staff will base their determination on the review of information submitted by the member or their authorized representative. The review will also consist of review of medical records and claims history.
3. All quality of care grievances are reviewed by a GNS and submitted to the CMO or physician designee for review within a timeframe, which is appropriate for the nature of the member's condition. If there is a potential safety issue determined by the GNS or QI Nurse, documentation of the issue will be reviewed by the QI department.

M. Inter-Rater Reliability (IRR)

1. To ensure that grievances are appropriately designated by the GNS as clinical versus non-clinical and referrals for PQIs are accurately being referred to the QI department, IRR studies will be conducted every quarter.
2. Sample will be prepared by the Grievance Manager or designee.
   a. PQI Referral Sample - A random selection of a minimum of 10 grievances will be pulled for review by the CMO or designee to determine whether the decision to not refer the case to QI as a PQI was appropriate.
   b. Clinical vs Non-Clinical Sample- A selection of a minimum of 10 grievances will be pulled for review by the CMO or designee to determine whether the categorization of a grievance, clinical or non-clinical was appropriate.
3. Timeframe – IRRs will be completed on a quarterly basis and reported to the Member Grievance Review Committee.
4. Results - A 90% IRR is required. Where a 90% score is not achieved, additional training will be provided to the GNS by the QI designated staff member and subsequent IRR studies will be

conducted until the passing score is achieved.

N. Grievances Involving Coverage For Terminally Ill Members
A member who has a terminal illness (incurable or irreversible condition that has a high probability of causing death within one (1) year or less) requires the following procedure for addressing a coverage denial.
1. Within five (5) business days of a denial of a benefit for treatment, services, or supplies deemed experimental as recommended by a participating plan provider, Partnership will provide to the member thefollowing information.
   a. A statement setting forth the specific medical and scientific reasons for denying coverage.
   b. A description of alternative treatment services or supplies covered by the plan, if any. Compliance with this subdivision Section 1368.1 of the Act, by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
   c. Copies of the plan's grievance procedures or grievance form. The grievance form shall provide an opportunity for the member to request a conference as part of the plan's grievance system provided under Section 1368.1.
2. If the member requests a conference, the conference will be held within five (5) business days if the treating participating physician determines, after consultation with the health plan Medical Director, based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies, or any alternative treatment, services, or supplies covered by the plan, would be materially reduced, if not provided at the earliest possible date. The member will also be given the option to extend the timeframe to request to participate in the conference up to 30 calendar days.

O. Contacting Providers Regarding Grievances Filed Against Them
1. Members are notified at the time of the filing that their grievance may be sent to the provider they are grieving about to receive a response regarding their grievance. Members may request that any notification to their provider or practitioner regarding the grievance be delayed until a relationship with a new provider or practitioner is effective. Such a request is noted when the grievance is filed by the Partnership staff member. Partnership staff will assure the member that there will be no discrimination against them by Partnership or its providers or practitioners on the grounds that they have filed a grievance.

P. Member Grievance Correspondence
1. There are two (2) types of member correspondence issued by grievance staff, the acknowledgment letter and resolution letter. When translation is required, a fully translated version of these letters will be mailed. Of note, each member correspondence includes Partnership's Nondiscrimination notice and the Your Rights under Medi-Cal Managed Care notice. ~~These noticesprovide the member information regarding Partnership's grievance process including the member's rightsto file for a second level grievance or state hearing if appropriate.~~ For discrimination grievances,the member will be provided information on disputing or appealing the decision with the U.S. Department of Health and Human Services, Office of Civil Rights.
   a. Acknowledgment Letter
      1) An acknowledgment letter is issued within five (5) calendar days of receipt of a grievance. This letter will include the date of receipt, name, address and phone number of the Partnership GCA who has been assigned to their case and the phone number for the California Relay Service.
      2) Exception to sending the acknowledgment letter
         a) If a grievance is resolved within five (5) calendar days of receipt, the GCA will issue only the resolution letter.
   b. Resolution Letter
      1) The GCA mails a resolution letter within 30 calendar days of the date the grievance was received. The letter summarizes the grievance and describes the resolution. If the outcome of the grievance includes an adverse benefit decision, the member will be advised of how to

appeal the decision in the resolution letter, and the "Your Rights" attachment will be included. ~~When applicable, the grievance resolution letter will provide second level grievance options. See Section S below for second level grievance definition.~~

Q. Time Frame - Grievance
   1. Standard:
      a. Member grievances are resolved within 30 calendar days of the member's requestfor a grievance [Title 22 CCR 53858 (f) (1)]. In the event that resolution of a standard grievance is not reached within 30 calendar days, Partnership will notify the member in writing of the status of the grievance and the estimated date of resolution.
   2. Expedited:
      a. Grievance staff will process the case within 72 hours from the date of receipt of the grievance.
   ~~3. Grievance acknowledgment letter will be sent to the member within five (5) calendar days of receiving the grievance.~~

R. Grievance File Maintenance
   Documentation for each grievance is maintained by the GCA. Documentation may include, but is not limited to the following:
   1. Memo outlining the grievance and the steps taken to resolve the issue;
      a. The date of the call
      b. The name of the complainant
      c. The complainant's member identification number
      d. The nature of the grievance
      e. The nature of the resolution
      f. The name of the plan representative who took the call and resolved the grievance
      g. Request for an Appeal or Grievance Form
      h. Acknowledgment Letter ~~and Frequently Asked Questions about the Grievance Process~~
      i. Additional written correspondence between Partnership, the member, providers and/or practitioners
      j. Billing and claims information (if appropriate)
      k. Medical Records Release Form (if appropriate)
      l. Medical records (if appropriate)
      m. Grievance resolution letter
      n. Notice of unresolved grievance~~,~~ (if appropriate)

~~S.~~ Copies of grievances and responses shall be maintained by Partnership for ten (10) years. ~~They are maintained on-site for two (2) years, and include a copy of all medical records, documents, evidenceof coverage and other relevant information upon which Partnership relied in reaching its decision.~~

~~T. Second Level Grievance~~
   ~~1. A second level grievance is an appeal of a grievance that has been denied. It provides the opportunity for a different team to investigate the case who was not involved in the original investigation. Examples of denied second level grievances include, but are not limited to:~~
      ~~a. Denial of a request for transportation due to protocols and/or guidelines~~
      ~~b. Denial of a request of transportation related to the mode of transportation~~
      ~~c. Any member dissatisfied with their initial denied grievance resolution~~
   ~~2. A second level grievance will follow standard grievance processing procedures with some exceptions.~~
      ~~a. The assigned GCA will be new to the investigation and not involved in theoriginal grievance case.~~
      ~~b. The assigned GNS will be new to the investigation and not involved in the original case.~~
      ~~c. If applicable, the assigned Medical Director will be new to the investigation and not involved in the original case or a subordinate of the Medical Director who participated in the prior decision.~~

~~d. Partnership will provide language services, bilingual staff or an interpreter, when appropriate.~~
~~e. Partnership will re-investigate the substance of the grievance using any additional informationprovided, along with original case documents and newly requested documents.~~
~~f. Partnership will document within the case summary, the substance of the second level grievance andactions taken, including any aspect of clinical care involved.~~
~~g. The second level grievance will follow the standard grievance processing timeframes of 30 calendar days and 72 hours if expedited. The acknowledgment letter will be sent to the member within five (5) calendar days.~~

MEMBER APPEAL PROCESS

~~U.~~S. Time Frame – Appeal

Appeals must be filed within 60 calendar days following any denial action that is the subject of the member's dissatisfaction. Appeals can be filed by the member, their authorized representative, or a provider on behalf of a member either orally or in writing. If a member files an oral appeal, the MSR or Grievance staff will request the member to provide a written, signed appeal. The oral appeal establishes the filing date of the appeal. Partnership will proceed with handling of the appeal if the written signed appeal is not received. There is only one level of appeal for members at the MCP level, per 42 CFR 438.402(b).

~~V.~~T. Resolving Member Appeals

1. Confirmation of member appeal
   a. Upon receipt of an appeal, Grievance staff conducts a preliminary investigation of the request by identifying the substance and reason for the appeal and reviewing any additional clinical and/or other information submitted with the appeal. The Grievance staff will review any previous denials, the appeal history, and the timeline of activities leading up to the current appeal, before contacting the treating provider, Partnership staff and any other appropriate individuals to gather information. Grievance staff will also contact the member to confirm the appeal and provide the member an opportunity to submit a statement for the reason for the appeal. When investigating the appeal, Partnership staff will not give deference to the denial decision.
2. Presentation of evidence, facts and law in support of member's grievance
   a. Members are advised of their rights to submit evidence, facts and law in support of their grievance and are given 10 calendar days to submit the documentation. Upon request, the member has the right to request reasonable access to their appeal case file, including medical records and any other documents before and during the appeal process.
3. Continuation of benefits (also known as aid paid pending)
   a. Grievance staff will assess if the member's benefit/service can continue pending the outcome of the appeal decision.
      1) The ~~criteria~~criterion for continuation of benefits ~~is~~are listed below per 42 CFR 438.420
         a) Requests must occur within 10 calendar days from the date the NOA was mailed to the member.
         b) The appeal must be filed timely.
         c) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
         d) The service was ordered by an authorized provider.
         e) The original period covered by the original authorization has not expired.
   b. Duration of continued or reinstated benefits
      1) If Partnership continues or reinstates the member's benefits while the appeal is pending, the benefits will be continued until one of the following occurs:
         a) The member withdraws ~~from~~ the appeal.
         b) 10 days after Partnership mails the NAR, or, if the member requests a state hearing

within the 10-day timeframe, the benefits will be continued until a state hearing decision is reached.

c) The state hearing office issues a hearing decision adverse to the member.

d) The time period or service limits of a previously authorized service has been met.

c. Partnership must pay for disputed services if the member received the disputed services while the appeal or state hearing was pending. Consistent with 22 CCR § 51002 regarding prohibitions in collecting reimbursement from Medi-Cal beneficiaries, Partnership must ensure the member is not billed for disputed services even if the final resolution of the appeal or state hearing is adverse to the member, that is, upholds Partnership's adverse benefit determination.

Policy/Procedure Number: CGA024 ~~(previously CGA 003; Health Services [HS] MCQP1034; Member Services [MS] policy #300)~~			**Lead Department: Administration** Business Unit: Grievance & Appeals
Policy/Procedure Title: Medi-Cal Member Grievance System			☒**External Policy** ☐**Internal Policy**
Original Date: 2/11/99 (MS 300)		**Next Review Date:** ~~02/14/2025~~02/12/2026 **Last Review Date:** ~~02/14/2024~~02/12/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒**Partnership Advantage**

~~W.~~U. Examples of Member Appeals

1. An appeal is a member's request for reconsideration of an initial decision resulting in the denial of service, benefit or claim. Appeals may address, but are not limited to, the following issues:
   a. Appeals of denied TARs
   b. Appeals of level-of-care determinations
   c. Appeals of Partnership claims payment denials
   d. Appeals of primary care physician request for disenrollment
2. Members filing grievance regarding their Medi-Cal eligibility are referred to their local county Health and Social Services Department or the Social Security Administration office for assistance.

~~X.~~V. Review of Appeals

1. Medically-Related Appeals
   a. Grievance staff will refer medically-related appeals and all documentation to the Medical Director for review who was not part of the original decision to deny, nor a subordinate of theoriginal decision maker, unless the final decision is in favor of the member (Contract Exhibit A,Attachment 14, 2, F). The "health care professional with appropriate expertise" is not determined by specialty, but by expertise and experience which varies with the career and experience of the particular Medical Director. In general, if the appeal is about a child, then a pediatrician or family physician Medical Director would be consulted. If the appeal is about an adult, then one of the internal medicine physicians or family physicians would be consulted. If the Medical Director reviewing the appeals feels that the particular clinical issue in question is outside their expertise or experience, they may refer the case to another Medical Director for review (who was not part of the original decision to deny, nor a subordinate of the original decision maker) or to an outside physician consultant with expertise in this area ~~(Contract Exhibit A Attachment 14, 2, C)~~.
      1) Ordering Medical Records
         The Medical Director will direct grievance staff to order medical records from primary care providers and/or other treating physicians if needed. Medical providers are expected to respond to requests for medical records within five (5) working days.
2. Other Appeals
   a. Appeals regarding claims, billing issues, special cases status and other non-medically-related cases may be presented to the Member Grievance Review Committee for departmental review of the resolution as needed. The staff reviewing the appeal will be individuals who were not involved in the initial determination nor a subordinate of the original decision maker unless the final decision is in favor of the member.
3. Expedited Appeals
   a. Requests for expedited appeals will be immediately forwarded to a Medical Director for review. If the expedited review is deemed medically necessary, the appeal resolution will be provided within 72 hours. The GCA will make reasonable efforts to notify the member orally and provide written notice within 72 hours.

~~Y.~~W. Member Correspondence

1. There are ~~three~~two (~~3~~2) types of member correspondence that are issued by Grievance staff. When translation is required, a fully translated version of these letters will be mailed.
   a. Acknowledgment Letter
      1) An acknowledgment letter is issued within five (5) calendar days of receipt of an appeal.
      2) This letter will include the receipt date, name, address and phone number of the GCA who has been assigned to their case and the phone number for the California Relay Service.

3) Exception to sending the acknowledgment letter
   a) If an appeal decision is rendered within five (5) calendar days of receipt, the GCA will issue only the appeal decision letter.
4) Denial of Expedited Review
   a) If a request for an expedited review has been denied by a Medical Director, grievance staff will also include in the acknowledgment notice that the request for an expedited review has been denied and the reason why the request was denied.

b. Notice of Appeal Resolution Letter
1) For pre service and post service appeals, the GCA mails an appeal resolution letter within 30 calendar days from the date the appeal was received. The letter summarizes the appeal and describes the appeal decision. Appeal decisions to uphold the denial include the rationale specific to the member's condition or reason for the request so the member or their representative understand what is needed to file the next level of appeal. The letter is written in easy-to-understand language that includes the complete explanation of the grounds for the denial, without the use of abbreviations or acronyms that are not defined or health care procedure codes that are not explained. The appeal resolution letter will reference to the benefit provision, guideline, protocol or criteria, which the appeal decision is based upon. Also the letter will notify members that they have access to all copies and documents that are relevant to the appeal, free of charge. The appeal resolution letter will also list the titles and qualifications, including specialties of individuals participating in the appeal review. All appeal resolution letters will include state hearing rights when appropriate. If any appeal resolution timeframe is not met by Partnership (i.e., standard or expedited), the member is considered to have exhausted Partnership's appeals process and may proceed to a state hearing.
2) Partnership will authorize or provide services for overturned adverse benefit determinations (as theresult of an appeal determination) as expeditiously as the member's health condition requires, but no later than 72 hours after the decision.

c. Notification
Each notification template (i.e., Notice of Appeal Resolution, "Your Rights" attachments) when informing members of a denial or appeal resolution will either be DHCS templates or be submitted to DHCS for review and approval prior to use. Member correspondence includes Partnership's Language Taglines, Nondiscrimination notice, and "Your Rights Under Medi-Cal Managed Care". These notices provide the member information regarding Partnership's grievance process including the member's rights to file a state hearing.

VII. MEMBER STATE HEARING PROCESS

A. Member State Hearing Timeframe
State Hearings must be filed within 120 calendar days following the date of the NAR that is subject of the member's dissatisfaction. State hearings can be filed by the member or their authorized representative. For the purpose of this policy, the term "member" will be used to refer to the member and their authorized representative unless otherwise noted.

B. Filing a State Hearing
1. Members have the right to file ~~for~~ a state hearing after exhausting Partnership's appeal process or in instances of deemed exhaustion as defined in III.F above.
2. Members can file ~~for~~ a state hearing with the California Department of Social Services. There are four ways to request a state hearing.
   a. By Phone
   Members can call the State Hearing Office at 1-800-743-8525. Hearing impaired members may use TTY by calling 1-800-952-8349.

b. By Mail
Members can send a hearing request form or their own written request directly to:
California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-43~~7~~3
Sacramento, CA 94244-2430

c. By Fax
Members can fax their hearing request form or their own written request directly to the state at 916-309-3487 or 833-281-0903.

d. In Person
Members can also turn in their hearing request form or their own written request at one of the local county offices.

3. Partnership will assist members with preparing for the State Hearing by providing the member with their case file, including medical records, other documents and records, guidelines, clinical criteria, and any new or additional evidence relied on for the initial or appeal denial.

C. Responding to State Hearing Requests

1. Notification of Hearing Request
Partnership receives a notice of the member's request for a state hearing from the SCOPE unit in theCalifornia State Department of Social Services and from the Office of the Ombudsman. Notifications include the case name, the request for hearing and filing date.

2. Review of Hearing Request
Upon receipt, grievance staff conducts a preliminary investigation of the request by contacting the treating provider, Partnership staff and any other appropriate individuals to gather information. Grievancestaff will also contact the member to confirm the state hearing and to also provide the member an opportunity to submit a statement for the reason for the hearing. If the member has not opened an appeal with Partnership, staff will offer to open an appeal as well.

3. Parties to State Hearings
The parties to the state hearings include Partnership, the member and their representative or therepresentative of a deceased member's estate.

4. Continuation of Benefit
   a. Upon request, the member's benefit/service can continue pending the outcome of the state hearing decision.
   b. The criteria for continuation of benefits are listed below per 42 CFR 438.420.
      1) Request must occur within 10 calendar days from the date the notice of action was mailedto the member.
      2) The state hearing must be filed timely.
      3) The state hearing involves the termination, suspension, or reduction of a previously authorized course of treatment.
      4) The service was ordered by an authorized provider.
      5) The original period covered by the original authorization has not expired.
   c. Duration of continued or reinstated benefits
   If Partnership continues or reinstates the member's benefit while the statehearing is pending, the benefits will be continued until one of the following occurs:
      1) The member withdraws ~~from~~ the state hearing
      2) The state hearing office issues a hearing decision adverse to the member
      3) The time period or service limits of a previously authorized service have been met

d. Disputes regarding continuation or reinstated benefits
In the event grievance staff finds that the member does not meet criteria for continuation or reinstated benefits, the member will be referred back to the Office of the Ombudsman to review and render a decision if aid paid pending applies.

D. Creation of Statement of Position
Grievance staff, while working with clinical Partnership staff, will prepare the Statement of Position. The Statement of Position will state the following information:
1. The Issue
2. The Background
3. Pertinent Facts
4. Guidelines
5. History of TAR
6. Applicable Law
7. Conclusion

E. Submission of Statement of Position
Statements of Positions are submitted directly to the state hearing SCOPE office, the Office of the Ombudsman, and to the member, at least two (2) working days prior to the scheduled hearing. To ensure receipt prior to the hearing. Partnership will upload it to the Appeals Case Management System (ACMS) The ACMS is the online website used to manage State Hearings. ~~email the Statement of Position via secure email to scopeofbenefits@dss.ca.gov and the Office of the Ombudsman.~~ Grievance staff will send the Statement of Position via FedEx to the member. FedEx envelopes will require direct signature for delivery. In the event a physical address cannot be obtained or is not available, Statement of Positions will be mailed via certified mail to the member's PO Box.

F. Representation during the State Hearing
1. Grievance staff will appear at the state hearings to represent Partnership and explain Partnership's position. Appropriate Partnership staff and/or other representatives may be asked to appear at the state hearings asdetermined necessary by the Medical Director.

G. Expedited State Hearings
1. Within two (2) working days of being notified by the Department of Social Services (DSS) or the Office of the Ombudsman that a member has filed a request for a state hearing which meets the criteria for expedited resolution, Partnership will deliver directly to the designated/appropriate DSS Administrative Law Judge, all information and documents which either support, or which Partnership considered in connection with, the action which is the subject of the expedited state hearing. This includes, but is not limited to, copies of the relevant TAR, NOA, and NAR. If the NOA or NAR are not in English, fully translated copies shall be transmitted to DSS along with copies of the original NOA and NAR. One or more plan representatives with knowledge of the member's condition and the reason(s) for the action, which is the subject of the expedited state hearing, shall be available by phone during the scheduled state hearing.

H. State Hearing Decisions
1. Per 42 CFR 431.244(f)(1), the State must issue a final decision on the state hearing within 90 calendar days of the date of request for hearing, this timeframe is detailed in the "Medi-Cal Your Rights" document enclosed with NOA/NARs. The notice of the Administrative Law Judge's decision will provide members with information on how to request a rehearing of their issue if they disagree with the decision. A member may obtain judicial review of the decision by filing a petition in Superior Court under Code of Civil Procedure§1094.5 within one year after the date of the decision.
   a. Upheld Decisions
   Decisions favorable to Partnership will be noted in the grievance system case file and closed. A copyof the decision is forwarded to the department that rendered the adverse decision to the member.

b. Overturned Decisions

Adverse decisions to Partnership will be noted in the grievance system case file. A copy of the decision is forwarded to the department that rendered the adverse decision to the member and will be given 72 hours to overturn the decision; expedited hearings will require the denial be overturned within 24 hours. Once confirmation is received that the decision is overturned, grievance staff will contact the member and the Office of the Ombudsman and verbally notify that the denial has been overturned. Interactions with the member and the Office of the Ombudsman are documented in the grievance system case file and the case is closed once a copy of the overturned decision is available. Partnership will pay for disputed services if the member received the disputed services while the State Hearing was pending.

I. State Hearing File Maintenance
   1. All documentation relating to a state hearing is scanned and uploaded into the grievance system under the member's case number. Documentation includes but is not limited to the following:
      a. Case Summary (produced out of grievance system) outlining the state hearing and the steps taken to resolve the issue
      b. Notification of State Hearing
      c. All written correspondence between Partnership, the member, providers and/or practitioners
      d. Billing and claims information (if applicable)
      e. Statement of Position
      f. Administrative Law Judge's decision on the hearing

J. Monitoring of Timeliness of Grievances
   1. All grievances, appeals and state hearing requests with their resolutions are documented in the grievance system.
   2. At the end of each month, the grievance system manager or their designee will review the grievance staff cases as part of their performance review. In addition, all grievances and appeals pending and unresolved for 30 days or more are reviewed.
   3. Monthly meetings, or more often if needed, are conducted with staff to ensure that member grievances and appeals are resolved within established timeframes as well as to review open member grievancesand appeals and determine appropriate resolutions.

K. Reporting Grievances to HealthPlan Committees for Review
   1. Under the direction and oversight of the CMO, individual and aggregate data on member grievances and appeals is reviewed by the Member Grievance Review Committee(MGRC), Internal Quality Improvement (IQI), and Quality/Utilization Advisory Committee (Q/UAC) no less than 4 times per year. Each committee reviews the data for possible actions as determined appropriate according to Partnership Quality Assurance Protocol. On a quarterly basis, all grievances related to access to care, quality of care and denial of services will be reviewed and analyzed by committee to remedy any problems identified. On an annual basis, Partnership's Consumer Advisory Committee (CAC) will review the written record of Grievance and Appeals.

VIII. EXEMPT GRIEVANCE PROCESS

A. Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the end of the following business day, are categorized as exempt grievances and are exempt from the requirement to send a written acknowledgment and response. If the exempt grievance is resolved by the end of the following business day, the grievance will remain categorized as "exempt". If the exempt grievance is not resolved by the end of the following business day, it will be processed as a standard grievance, with the rights of the standard grievance timelines. All grievances are clearly listed on a universal grievance log.

B. All exempt grievances are reviewed by the GNS within three (3) days to determine whether the grievance has potential quality of medical care issues. The GNS will base their determination on the review of information submitted by the member or authorized representative. The review may also consist of a review of medical records already obtained by Partnership for utilization management purposes, care coordination notes and claims history. If the GNS determines a clinical issue identified, they will submit the exempt grievance to the CMO or physician designee for review within a timeframe, which is appropriate for the nature of the member's condition. Either the GNS or the CMO/physician designee may determine, based on their clinical judgement, that the exempt grievance warrants individual attention by a Partnership department, and refer the case for intervention (similar to interventions done for non-exempt grievances, summarized in section G.2.d, Resolving Member Grievances, above).

IX. REPORTING REQUIREMENTS

A. Partnership maintains an inquiry log of all requests for information that do not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Partnership processes.

B. Partnership maintains and has available for DHCS' review, Partnership's grievance logs, including copies of the grievance logs of any subcontracting entity delegated with the responsibility to maintain and resolve grievances and the Partnership exempt grievance log. Grievance logs are maintained based on the requirementsset forth in Title 22 CCR Section 53858 (e).
   1. Date and time the grievance was filed
   2. The name of the member filing the grievance
   3. Member identification number
   4. The name of the person receiving the grievance
   5. A description of the grievance
   6. A description of the action taken to resolve the grievance
   7. The proposed resolution by the plan
   8. The name of the person responsible for resolution
   9. The date of notification to the member

C. The information contained in this log shall be reviewed by Partnership's Board and Partnership's CMO or physician designee on an annual basis. ~~Partnership also submits quarterly grievance reports based on Title 28 CCR Section 1300.68(f).~~

X. MEDICAL RECORDS/DOCUMENT REQUESTS:

A. Members and providers may call to request materials and/or letters related to their Grievance/Appeal/State Hearing to be sent to them by mail or by fax.

B. Members can request ~~materials/documents/records~~their case file free of charge by calling Partnership's Member Servicesdepartment ~~or by filling out the Grievance Records Request form~~.

XI. REFERENCES:

A. Partnership Contract 08-85215 A19
B. 22 CCR §53858
C. 22 CCR § 51002
D. 28 CCR §1300.68 [except subdivision §1300.68(c),(g) and (h)]
E. 28 CCR §1300.68.01[except subdivision §1300.68.01(b)and (c)]
F. 42 CFR 438.420(a)(b) and (c)
G. 42 CFR 438.406(b)(3)
H. California Department of Health Care Services (DHCS) All Plan Letter (APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (revised May 3,

2022, supersedes APL 17-011)

I. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (Aug. 31, 2021, supersedes APL17-006)
J. DHCS APL 22-002 Alternative Format Selection for Members with Visual Impairments (March 12, 2022)
K. NCQA 202~~3~~5 Standards and Guidelines: Member Experience 7A-7B
L. NCQA 202~~3~~5 Standards and Guidelines: Utilization Management 8A-9A-9B-9C-9D

XII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

XIII. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Grievance & Appeals Compliance Manager

XIV. REVISION DATES:

Medi-Cal
MS- 06/4/99; 04/25/00; 05/17/00; 06/19/00; 07/09/02; 10/25/02; 02/19/03; 02/23/04; 05/11/04; 01/17/06; 01/16/08; 03/18/09; 07/21/10; 03/20/13; 11/18/15; 06/21/17; 03/13/19; 3/11/20; 5/12/21; 08/10/22; 10/11/23; 02/14/24; 2/12/25

PREVIOUSLY APPLIED TO: N/A

YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE

STATE HEARING

If you still do not agree with this decision, you can ask for a State Hearing and a judge will review your case. You will not have to pay for a State Hearing.

If you want a State Hearing, you must ask for one within 120 days from the date of this Notice of Appeal Resolution (NAR) letter. However, if your health plan continued to provide you with the disputed service(s) (Aid Paid Pending) during the health plan's appeal process and you want the service(s) to continue until there is a decision on your State Hearing, you must request a State Hearing within 10 days of this Notice of Appeal Resolution letter. Even though your health plan must give you Aid Paid Pending when you ask for a State Hearing in this way, you should let your health plan know you want to get Aid Paid Pending until your State Hearing is decided. You should contact Partnership HealthPlan of California (PHC) between 8 a.m. – 5 p.m. by calling (800) 863-4155. If you cannot hear or speak well, please call (800) 735-2929 or California Relay 711.

You can ask for a State Hearing in the following ways:

- Online at www.cdss.ca.gov

- By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.

- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

  Mail: California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-433
  Sacramento, CA 94244-2430

  Fax: (916) 309-3487 or toll-free at 1-833-281-0903

  A State Hearing Form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number and/or CIN number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an Expedited Hearing and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself. Or, someone like a relative, friend, advocate, doctor, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearings Division that the person is allowed to speak for you. This person is called an Authorized Representative.

LEGAL HELP

You may be able to get free legal help. Call the California Department of Consumer Affairs at (800) 952-5210, or TTY (800) 326-2297 You may also call the local Legal Aid Society in your county at 1-888-804-3536.

MEMBER GRIEVANCE AND APPEAL FORM INSTRUCTIONS

OUR MISSION: Helping our members, and the communities we serve, be healthy

Your point of view matters! We want you to have the best care and service possible. If you have a problem while using your Partnership HealthPlan of California Medi-Cal plan, you have the right to file a Grievance or an Appeal. Complete the attached form. Tell us what happened and how we can help. Explain why you are not happy with your experience or why your benefit or service should be approved. When you tell us about your problem, it helps us improve care for all members. Cases are usually investigated within 30 days. We will not discriminate or retaliate against you for filing a case. If you choose to have someone represent you, they must have authorization on file with Partnership. If you are having problems with your Medi-Cal eligibility, please call your County Eligibility Worker.

What is a Grievance?

Are you unhappy with your service? A Grievance is a request for Partnership to review a problem with services you received from your provider or Partnership. An example of a Grievance is waiting too long to receive an appointment with your doctor. There is no time limit for filing a Grievance.

What is an Appeal?

An Appeal is a request for Partnership to review a decision made about a benefit or service that has been denied, limited, or stopped. It also includes not paying for covered services. An example of an Appeal is if you disagree with a denied surgery. You must file your Appeal within **60 calendar days** from the date on the Notice of Action (NOA) letter. The NOA letter tells you why we denied a benefit.

How to File a Grievance or Appeal

(800) 863-4155 or (800) 735-2929 (TTY)
Call Member Services Monday through Friday from 8 a.m. – 5 p.m. for help with filing a case. Ask Member Services for an interpreter or other language assistance services if you need help communicating.

You can also file your case online, by mail, fax or in person.

Partnership HealthPlan of California
ATTN: Grievance & Appeals Dept.
4665 Business Center Drive
Fairfield, CA 94534

File by fax at:
(707) 863-4351

File online at:
www.partnershiphp.org

File in person at:
Fairfield: 4665 Business Center Drive, Fairfield, CA
Redding: 3688 Avtech Parkway, Redding, CA

If you are unhappy with the decision of any Appeal, you can file a State Hearing with the California Department of Social Services. Call **(800) 952-5253** for assistance.

INSTRUCTIONS FOR PROVIDER/OFFICE STAFF

If a member expresses any problems during their visit, they can file a case using any method above or by completing this form. You or the member can fax the completed form to **(707) 863-4351**. PHC will investigate their concerns. PHC will not share the results of the investigation with the provider or its office. If you have any questions about the Grievance and Appeals process, please contact your Partnership Provider Relations Representative. Partnership policies and procedures prevent any party from retaliating against any person who files a case or participates in the investigation of a Grievance or Appeal.

MEMBER GRIEVANCE AND APPEAL FORM

Today's Date:	**Case Type:** ☐ Grievance ☐ Appeal ☐ Do Not Know	
MEMBER INFORMATION		
Member Name:	**Member ID/CIN:**	**Date of Birth:**
Mailing Address:	**City:**	**Zip:**
Phone Number:	**Alternate Phone Number:**	
Name of Person Completing Form:	**Person Completing Form**: ☐ Member ☐ Authorized Representative ☐ Other	
NATURE OF GRIEVANCE OR APPEAL		
Date of problem:	**Where did the problem take place?**	
Who was involved?		
Briefly describe the problem. Include any information that may be helpful in researching your case.		
If we denied a benefit, write the authorization # from the NOA letter. If it is missing, write the date of service(s).		
RESOLUTION		
What steps have you taken to fix the problem?		
How can PHC help?		

Member Signature:	**Date:**

Mail To: Partnership, 4665 Business Center Dr., Fairfield, CA 94534 **Phone**: (800) 863-4155 **FAX**: (707) 863-4351

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Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Jan. 15, 2025 Quality/Utilization Advisory Committee (Q/UAC) meeting. Please look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Quality Improvement – *Mark Netherda, MD, Medical Director for Quality*			
MCQP1053 – Peer Review Committee	223 - 227	**It was decided at Jan. 7 IQI that the policy alpha designation will remain "MP" (multi-program) because this policy may apply in part to "Partnership Advantage," the Medicare product line implementing in eight counties, effective Jan. 1, 2026.** **Section V. Purpose:** Updated to read: The PRC reviews concerns and complaints about the quality of clinical care and services provided to Partnership HealthPlan of California's (Partnership's) members and makes recommendation for actions to prevent reoccurrence of any issues. PRC also reviews sentinel conditions identified as having quality concerns. PRC discussions and documents are protected by federal and state laws governing confidentiality of health care peer review activities conducted in good faith. **VI.A.1. Membership is updated** to allow for certain recently retired physicians to participate as PRC members: "Medi-Cal population experienced physicians who have recently retired from practice within the last two years are also eligible to serve on the PRC."	Health Services
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director, UM Regulations*			
MCUG3022 – Incontinence Guidelines	229 - 238	Per discussion at the December OCMO meeting, this policy was updated (in Attachment A) to remove the prior authorization requirement for non-sterile gloves. Code A4927 will now be covered as per Medi-Cal guidelines for a quantity of 200/month with no prior authorization requirement. This adjustment will need to be configured in our system.	Configuration Member Services
MCUP3104 – Transplant Authorization Process	239 - 244	**Section VI.A. Footnote 1:** " Magellan" was removed and replaced with " DHCS-contracted pharmacy administrator." **Section VI.B. 6:** During our annual review of this policy, we reviewed the time frames for Direct Member assignment to Health Plan 5 for Continuity of Care for transplant patients. Adjustment was made at VI.B. 6.a. and b. to specify that while Members are generally assigned to Health Plan 5 for 12 months and then re-evaluated for continued need, there are two transplant types where the Direct Member status is longer: a. Heart transplant recipients are granted H5 for plan lifetime. b. Bone Marrow transplant Members (including CAR T-cell therapy and gene therapy) become eligible for assignment to a PCP two years after receiving the transplant, but may qualify for continued H5 based on continuity of care criteria as detailed in policy MCUP3039 Direct Members. **Section VII. References F. – P.** Additional DHCS Provider Manual sections were identified for Chemotherapy drugs	Configuration Member Services Providers Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director, UM Regulations, & Robert Moore, MD, Chief Medical Officer*			
MCUP3113 – Telehealth Services	*245 – 272 CLEAN copy begins on p. 261*	During this annual review, the Telehealth policy was updated and reorganized for clarity. Additional codes were also added as well as descriptions of modifiers. **Section I:** The following Related Policies were added: F. MPCR200 - Credentials Committee and CMO Credentialing Program Responsibilities G. MCND9006 - Doula Services Benefit H. MCCP2033- Community Health Worker (CHW) Services Benefit I. MCCP2032- CalAIM Enhanced Care Management (ECM) **Section III:** A definition was added for D: E&M: Evaluation and Management **Section V:** The Purpose section was updated to provide only a brief statement. Information on the history of telehealth was removed. **Section VI:** The body of this policy was reorganized to provide more hierarchy and formatting. The three telehealth services models are defined at **VI.B**. as follows: 1. Synchronous Telehealth Services 2. Synchronous Patient to Provider Telehealth Services 3. Asynchronous Telehealth Services/ and Settings "Store and Forward"/ E-Consults The Reimbursement process for each model is defined in detail at Section **VI.H**. **Sections VI.H.1.b. and VI.H.3.c:** Language has been added to describe the required use of Place of Service codes 02 (indicates that telehealth services were provided to a patient in a location other than their home) and 10 (indicates that the patient was in their home while receiving telehealth services) and to specify that the Place of Service Code requirement is not applicable for FQHCs, RHCs or Tribal Health Centers. **Sections VI.H.1.b. and throughout:** Replaced Indian Health Services (IHS) term with "Tribal Health Centers" except where the IHS Memorandum of Agreement (MOA) rate is specifically mentioned. **Sections VI.H.1.c. and VI.H.2.b.** Language was modified at VI.H.1.c. to say "Each telehealth provider must be licensed in the State of California *(if a licensure pathway is available)."* This change accommodates the additions of non-licensed care personnel such as Doulas and Community Health Workers which was added at VI.H.2.b. **Section VI.H.1.f.2)** Updated Partnership department in charge of specialist contracts to be "Network Services" instead of "Provider Relations." **Section VI.H.1.f. Table Billing guidelines for Distant Site Providers (Traditional Synchronous Telehealth Services):** Added specific codes allowed for Telehealth for ACE Screenings, Mental Health Assessment, Perinatal Educational Counseling and Other Covered Procedures. Clarified codes that are excluded from Telehealth. **Section VI.H.2.a.** Correction was made to say that a licensed provider who provides E&M services for a patient utilizing telehealth technology to access the provider's office may	Configuration OpEx/PMO Provider Relations Network Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		submit claims for this service using the E&M code ***with*** the .93 or .95 modifier. This section previously said "without" which was incorrect. **Section VI.H.2.d. Table: Billing Guidelines for the Provider Site (Synchronous: Provider to Patient Telehealth Services):** Added code T1015 as an E&M code that may be billed as Licensed Provider Fee. Also ~~updated~~ deleted codes for Virtual Therapy procedures ~~that can be provided by telemedicine.~~that were only allowed during COVID-19. **Section VI.H.3.d. Table Billing guidelines for Originating Site Providers (Asynchronous Telehealth Services):** Added code T1015 as an E&M code that may be billed as Licensed Provider Fee. **Section VI.H.3.f.3)** A new table was added for Originating Store and Forward Site (E-Consult) with code 99452 specified. **Section VII. References:** Additional sections of the DHCS Provider Manual were added as References including Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (rural); Tribal Federally Qualified Health Centers (tribal fqhc); Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics (ind health). Welfare and Institutions Codes (WIC) § 14132.725 was also added as Reference C.	

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPQP1053</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Peer Review Committee</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 09/17/2014</td><td colspan="4">Next Review Date: ~~02/14/2025~~02/12/2026
Last Review Date: ~~02/14/2024~~02/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒~~☐~~ Partnership Advantage [1]</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~02/14/2024~~02/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. CMP10 – Confidentiality
B. MPQP1008 – Conflict of Interest Policy for QI Activities
C. MPQP1016 – Potential Quality Issue Investigation and Resolution
D. MPCR602 – Reporting Actions to Authorities
E. CMP36 – Delegation Oversight and Monitoring
F. MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines

II. IMPACTED DEPTS:

Health Services

III. DEFINITIONS:

A. Non-Physician Medical Practitioners (NPMP) are defined as nurse practitioners, physician assistants (PA), certified nurse midwives (CNM) and licensed midwives (LM)

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

~~The Peer Review Committee (PRC) investigates patient or practitioner complaints about the quality of clinical care provided by Partnership HealthPlan of California's (Partnership's) contracted providers and makes recommendations for corrective action. PRC also reviews sentinel conditions identified as having quality concerns. PRC discussions and documents are protected by federal and state laws governing confidentiality of health care peer review activities conducted in good faith.~~ The Peer Review Committee (PRC) reviews concerns and complaints about the quality of clinical care and services provided to Partnership HealthPlan of California's (Partnership's) members and makes recommendation for actions to prevent reoccurrence of any issues. PRC also reviews sentinel conditions identified as having quality concerns. PRC discussions and documents are protected by federal and state laws governing confidentiality of health care peer review activities conducted in good faith.

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules.

Policy/Procedure Number: MPQP1053			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Peer Review Committee			☒ **External Policy** ☐ **Internal Policy**
Original Date: 09/17/2014		**Next Review Date: 02/14/202502/12/2026** **Last Review Date: 02/14/202402/12/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**☐

VI. POLICY / PROCEDURE:

A. Committee Structure

1. Membership
   a. ~~External Physician Members:~~ The PRC is comprised of one or more licensed physicians in primary care~~ representatives from primary practice specialties~~ (e.g., Family Medicine, Internal Medicine and Pediatrics), and one or more specialist physicians (e.g., OB/GYN, General Surgery~~.~~)~~ These members represent licensed providers for~~ currently practicing in hospitals, medical groups, and practice sites ~~in geographic sections of~~contracted with ~~-~~Partnership~~'s~~ ~~or~~ otherwise regularly seeing Medi-Cal members. ~~service area.~~ Medi-Cal population experienced physicians who have retired from practice within the last two years are also eligible to serve on the PRC. There will be a minimum of three external physician members on the PRC. There is no upper limit to the number of standing members on the PRC.
   b. NPMPs as defined in MPQG1011 who are currently practicing within Partnership's service area may also serve as PRC members. There is no defined number of any type of NPMP who may serve on the PRC.
   c. Partnership staff physicians are voting members of the PRC and include, but are not limited to, the Chief Medical Officer, the Medical Director for Quality, the Behavioral Health Clinical Director, the Medical Director for Medicare Services, and Regional and Associate Medical Directors as assigned by the CMO.
   d. Additional Partnership non-voting staff attending and supporting the PRC include the Senior Director of Health Services; the Director of Pharmacy or designee; the Director of Health Equity; members of the Quality Assurance & Member Safety and Clinical Quality & Member Safety teams.
   e. Members serve open terms and may elect to resign at any time by formally advising the chair.
   f. Members with annual attendance of < 50% may be barred from future participation in the PRC.
2. Chair: The Chief Medical Officer (CMO) chairs the PRC. When the CMO is unavailable, the Medical Director for Quality is the designated chair. A Regional or Associate Medical Director acts as the temporary chair when needed. The role of the Chair is to assure that all quality matters and concerns are evaluated thoroughly, that there is adequate input to the discussion, that a reasonable effort is made to obtain the facts of the matter, and that matters are fully investigated and any actions are completed. The Chair must assure that the process follows protocol; is fair and unbiased at all times, and that a provider under scrutiny has had adequate notice and an opportunity to defend him or herself and has had due process.
3. Meetings: The PRC meets at least quarterly and on an as-needed basis.
4. Dual Capacity: External physicians and NPMPs are also voting members of the Quality/Utilization Advisory Committee (Q/UAC).
5. Compensation: External members are eligible to receive a financial stipend for each Q/UAC **or** PRC meeting attended.
6. Voting: Internal and external physician and NPMP members constitute the voting membership, with the Chair serving in a tie breaking capacity as necessary. A quorum is not required for a meeting to occur, except where a formal action needs to take place or in instances where the Chair determines that a quorum is necessary. In this case, the PRC's quorum is comprised of more than 50% of the voting membership. The Chair may not be counted for purposes of a quorum.
   a. NPMPs may vote to score providers and/or systems only in areas in which they possess subject matter expertise. For example, CNMs and LMs may vote only in cases involving obstetrics. Nurse Practitioners and PAs may vote only in cases involving their area(s) of practice, such as outpatient primary care, hospital care, pediatrics, internal or family medicine.
7. Confidentiality: To preserve an atmosphere promoting free and open discussion between and among committee members, each external member signs an annual Confidentiality Statement prepared and

retained by Partnership. This statement signifies the intent to protect individuals against misuse of information and to ensure that all information, medical or otherwise, regarding patients, practitioners and providers is handled in a confidential manner. Partnership staff ~~is~~ are governed by similar confidentiality policies.

8. Conflict of Interest: The integrity of the Peer Review process requires prevention of input and decision making where a conflict of interest exists. All non-Partnership~~PHC~~ clinicians taking part in the peer review process, including those on the PRC, are required to adhere to Partnership's Conflict of Interest (MPQP1008) policy. Each external~~-~~ PRC member signs an annual Conflict of Interest Statement prepared and retained by Partnership. Partnership staff ~~is~~ are governed by similar conflict of interest policies.

B. Committee Responsibilities
   1. The PRC will carefully review the clinical care in all situations in which a quality concern has been raised and forwarded for committee review. See MPQP1016 - Potential Quality Issue Investigation and Resolution for details of this process.
   2. The PRC will evaluate the quality concern related to the clinical care and determine whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards.
   3. Minutes are maintained according to the Confidentiality policy CMP10.
   4. External Peer Review
      a. Circumstances that require external review:
         1) The need for specialty review when there are no medical staff members within the PRC of the same or similar specialty;
         2) The PRC cannot make a determination and requests external review;
         3) The individual whose case is under review requests external peer review;
         4) When dealing with potential litigation that might affect a provider's contracted status;
         5) When dealing with ambiguous or conflicting recommendations from internal reviewers, or when there does not appear to be a strong consensus for a particular recommendation.
   5. Subcommittees: Complex or specialized peer review issues may be reviewed by a PRC subcommittee. These subcommittees meet on an *ad hoc* basis when cases identified through the peer review process require specialized peer review. A minimum of three clinicians are assigned to any peer review subcommittee. A minimum of 50% of subcommittee members must participate to take action. The notes, findings and recommendations of peer review subcommittee are presented to the next regular peer review meeting for deliberation. The principles of evaluation, confidentiality and recommended rating are the same as for the PRC as a whole. *Ad hoc* subcommittees may be created at the discretion of the CMO or PRC. There are two standing subcommittees:
      a. Medication Safety Subcommittee: This subcommittee evaluates potential quality issues referred by the Quality department related to appropriate use of opioid medications in patients with a diagnosis of chronic pain. Members of this subcommittee will include at least one specialist board certified in pain management and one behavioral health provider.
      b. Substance Use Services Subcommittee: This subcommittee evaluates potential quality issues referred by the Quality department related to the provision of services related to the treatment of Substance Use Disorder (SUD). The subcommittee will be chaired by the Behavioral Health Clinical Director, and include at least one outside specialist experienced in addiction treatment or in addiction medicine.

C. Confidentiality
   1. As specified in State statute (Cal. Civ. Code §43.7.), peer review activities are not subject to discovery. The members of the PRC and the records associated with its reviews and actions shall be afforded all of the immunity, protection and privileges under California law. A practitioner under review shall be afforded all rights and protections under California law. The PRC and the CMO

shall take all reasonable steps to protect the confidentiality of the committee's deliberations, reviews and actions, including all information obtained at all stages of the investigation, review and decision making process. Any confidential health information obtained during the course of peer review investigations shall be protected from loss, tampering, alteration and unauthorized or inadvertent disclosure of information.

D. Indemnification
   1. Partnership will indemnify, defend and hold harmless the members of the PRC from and against losses and expenses (including attorneys' fees, judgments, settlement and other costs, direct or indirect) incurred or suffered by reason or based upon any threatened, pending or completed action, suit, proceeding, investigation or other dispute relating or pertaining to any alleged act or failure to act within the scope or quality assessment activities as a member of the PRC. Partnership will retain the responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against PRC members, including, but not limited to, selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on the PRC member's good-faith belief that his or her actions and/or communications are reasonable and warranted and in furtherance of Partnership's peer review, quality assessment, or quality improvement responsibilities. , In no event will Partnership indemnify a member for acts of omissions taken in bad faith or in pursuit of the member's private economic interests.

E. Oversight
   1. The PRC is accountable to Partnership's Board of Commissioners on Medical Care.

F. Delegation Oversight and Monitoring
   1. Partnership may delegate Potential Quality Issue (PQI) investigation, including PRC oversight.
   2. A formal agreement is maintained and inclusive of all delegated functions.
   3. Partnership will review related policies and procedures and annual summary reports of findings and actions taken as a result of the PQI review process and provide feedback as part of Partnership's annual oversight audit.
   4. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:

A. Cal. Civ. Code §43.7. Immunity from liability; mental health professional quality assurance committees; professional societies, members or staff; peer review or insurance underwriting committees; hospital governing board

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV&sectionNum=43.7.

VIII. DISTRIBUTION:

A. ~~PHC~~ Partnership Provider Manual
B. ~~PHC~~ Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer or designee

X. REVISION DATES:

09/17/14; 11/19/14; 01/20/16; 3/16/16; 3/15/17,* 06/13/18; 05/08/19; 5/13/20; 5/12/21; 06/08/22; 06/14/23; 02/14/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

Policy/Procedure Number: MPQP1053			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Peer Review Committee			☒ **External Policy** ☐ **Internal Policy**
Original Date: 09/17/2014		**Next Review Date: 02/14/202502/12/2026** **Last Review Date: 02/14/202402/12/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**~~☐~~

PREVIOUSLY APPLIED TO:
N/A

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3022 (previously UG100322)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Incontinence Guidelines</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 07/24/1994</td><td colspan="4">Next Review Date: ~~10/09/2025~~02/12/2026
Last Review Date: ~~10/09/2024~~02/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~10/09/2024~~02/12/2025</td></tr>
</table>

I. RELATED POLICIES:

MCUP3041 – Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Medical Practitioner: For the purposes of this policy, the medical practitioner is a physician, nurse practitioner or physician assistant.
B. CMN Form: Incontinence Supplies Medical Necessity Certification Form *DHCS 6187*

IV. ATTACHMENTS:

A. Partnership Maximum/ Average Benefit Incontinence Guidelines
B. Incontinence Supplies Medical Necessity Certification form (DHCS 6187)

V. PURPOSE:

Incontinence supplies are a Medi-Cal benefit that must be prescribed by the physician, nurse practitioner, or physician assistant (medical practitioner) who is currently responsible for the care of the Member and has evaluated the Member's bladder and bowel incontinence within the past year. All Members with a diagnosis of incontinence should be evaluated by the current medical practitioner to determine whether consultation with a specialist is indicated.

VI. GUIDELINE / PROCEDURE:

A. TREATMENT AUTHORIZATION REQUEST (TAR) PROCESS
   1. A TAR is required for all incontinence supplies*. The TAR must contain documentation regarding the Member's history of incontinence, along with information regarding the medical necessity for the supplies ordered.
   2. For incontinence supplies over $165 per month (including sales tax), a state mandated Incontinence Supplies Medical Necessity Certification Form *DHCS 6187* (Attachment B) must accompany the TAR and will include the following information:
      a. Medical condition / diagnosis causing bowel and bladder incontinence
      b. Type of urinary / bowel incontinence

*See VI.A.3 for two code exceptions.

c. Evaluation and treatments attempted and outcomes (including urologist assessment or reports)
d. Documentation of the reasons why other options (pharmacologic, drugs, behavioral techniques or surgical interventions) are not appropriate to decrease or eliminate incontinence
e. Prognosis for controlling incontinence
f. Brief summary of the incontinence therapeutic intervention plan
g. Explanation if medical practitioner orders supplies in **excess** of the thresholds listed in Attachment A and information regarding medical necessity for the additional use

3. Codes A4335 and A6250 for skin wash and skin cream do not require a TAR unless they are ordered above normal supply limit. (See Attachment A for supply limits.) However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be valid for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.
4. The requested item must be the lowest cost item to meet the Member's medical needs.
5. If the Member has chronic, non-treatable incontinence as confirmed by the primary care practitioner or a urologist, the TAR can be approved up to one (1) year.
6. If the approval is granted for an interval greater than 30 days, the provider of service has the responsibility to verify that the Member remains eligible with Partnership HealthPlan of California (Partnership) on a monthly basis and in NO instance will Partnership reimburse for supplies in excess of a 60 day supply dispensed at any one time. (For Example: If Partnership approves supplies for a one year time frame, the provider will NOT be reimbursed for the entire year at one time. Billings are to occur incrementally on a monthly basis as the Member's eligibility status may change.) See Attachment A for supply limits.
7. Incontinence supplies such as diapers, liners, chux, etc. over $165 per month (including sales tax) require a completed Incontinence Supplies Medical Necessity Certification Form *DHCS 6187* (CMN form) (see Attachment B) submitted with the TAR.
8. Incontinence supplies $165 per month or less require a TAR with the prescription attached, but do not require the CMN form.
9. Note that the "NU" code modifier is NOT to be used for disposable incontinence supplies.

B. Incontinence supplies for Members in a skilled nursing facility (SNF) and Intermediate Care Facility (ICF)/Developmentally Disabled (DD) or ICF are part of the facility per diem rate and are not billable separately to Partnership. Incontinence supplies for Members in ICF/DD- Habilitative (H) or ICF/DD- Nursing (N) are not part of the facility per diem and are separately billable to Partnership. Incontinence supplies for Members in ICF/DD-H or ICF/DD-N can be approved for up to one (1) year. The same requirements as per VI.A.7 apply.
C. Incontinence supplies for Members under age five may be covered under the Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services benefit (now referred to as Medi-Cal for Kids and Teens) where the incontinence is due to a chronic physical or mental condition, including cerebral palsy and developmental delay, and at an age when the child would normally be expected to achieve continence.
D. The CMN form (Attachment B) must be dated within 12 months of the date of service on the claim and must be signed by the Member's current medical practitioner.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Incontinence Medical Supplies *(incont)*
B. Department of Health Care Services (DHCS) California Children's Services (CCS) Numbered Letter (NL) 11-1223 Authorization for Purchase of Incontinence Medical Supplies (12/19/2023)
C. Welfare & Institutions Code, Section 14125.4

Guideline/Procedure Number: MCUG3022 (previously UG100322)		**Lead Department: Health Services**
Guideline/Procedure Title: Incontinence Guidelines		**☒External Policy** **☐Internal Policy**
Original Date: 07/24/1994	**Next Review Date: ~~10/09/2025~~02/12/2026** **Last Review Date: 02/12/2025~~10/09/2024~~**	
Applies to:	**☒ Medi-Cal**	**☐ Employees**

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 01/01/96; 04/28/00; 06/20/01; 04/21/04; 02/16/05; 03/15/06; 08/20/08; 11/18/09; 07/21/10; 06/20/12; 08/20/14; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 11/13/19; 02/12/20; 06/10/20; 09/09/20; 02/10/21; 05/12/21; 08/11/21; 08/10/22; 09/13/23; 10/09/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, California 94534

~~PHC~~ PARTNERSHIP MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

DESCRIPTION OF PRODUCTS	HCPCS	MCL QTY
DISPOSABLE INCONTINENCE PRODUCTS (BRIEFS/ DIAPERS):	***See Note 1 below***	
Adult Sizes:		
Small	T4521	200/Month
Medium/ Regular	T4522	192/Month
Large	T4523	216/Month
Extra-Large (XL) and XXL	T4524	192/Month
Bariatric XXXL or above	T4543	200/Month
Youth Size:	T4533	200/Month
Pediatric Sizes:		
Small/Medium	T4529	200/Month
Large	T4530	200/Month
DISPOSABLE INCONTINENCE PRODUCTS (PROTECTIVE UNDERWEAR/ PULL-ONS):	***See Note 1 below***	
Adult Sizes:		
Small	T4525	120/Month
Medium	T4526	120/Month
Large	T4527	120/Month
Extra-Large (XL) and XXL	T4528	120/Month
Bariatric XXXL or above	T4544	120/Month
Youth Size:	T4534	200/Month
Pediatric Sizes:		
Small/Medium	T4531	200/Month
Large	T4532	200/Month
Note 1: Quantity limits for Disposable Incontinence Products **(Briefs/ Diapers)** and Disposable Incontinence Products **(Protective Underwear/ Pull-Ons)** cannot be combined without medical justification (which must be stated in Section C, field 12. on the DHCS form 6187 Incontinence Supplies Medical Necessity Certification which is Attachment B to this policy). If justification is provided, Briefs/ Diapers and Disposable Incontinence Products (Protective Underwear/ Pull-Ons) may be mixed and matched as long the combined total does not exceed 300 units. Also note that the "NU" code modifier is NOT to be used for disposable incontinence supplies.		
DISPOSABLE LINERS/ SHIELDS/ PADS/ UNDERGARMENTS:	***See Note 2 below***	
Disposable Liners/ Shields	T4535	180/Month
Disposable Pads	T4535	180/Month
Beltless Undergarments	T4535	180/Month
Belted Undergarments	T4535	180/Month
Note 2: Specific qty. limits apply to each product type. In this section, liners/shields, pads & undergarments may be mixed and matched as long as no single product type exceeds 180 units AND the combined total does not exceed 300 units of these items. Also note that the "NU" code modifier is NOT to be used for disposable incontinence supplies.		

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~~PHC~~ PARTNERSHIP MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

DESCRIPTION OF PRODUCTS		HCPCS	MCL QTY
Disposable Underpads:			
Large Underpad		T4541	120/Month
Small Underpad		T4542	120/Month
Incontinent Reusable Pants (Any Size):		T4536	2/Month
Reusable Waterproof Sheeting:		T4537	2/Year
Incontinence Skin Care:			
Skin Cream	***See Note 3 below***	A6250	540 gm/ Month
Skin Wash	***See Note 3 below***	A4335	960 ml/ Month
Enter in the system in cc's (8 oz. tube = 270 cc)			
Note 3: Skin Cream and Skin Wash Codes A4335 and A6250 do not require a TAR unless they are ordered above normal frequency limit. However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be good for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.			
Gloves:			
Non-Sterile Gloves	~~***See Note 4 below***~~	A4927	200/Month
~~**Note 4:** These are not routinely approved, and there must be a clear need for the item. Diagnoses of quad/paraplegia, AIDS, hepatitis, etc., are considered appropriate reasons for gloves. PHC will also consider approval if the caregiver of an adult is not a family member.~~			

Additional Notes:

(Applies to All): Kimberly-Clark Products are not a Medi-Cal Benefit

Enuresis Alarm Pads are a covered benefit as described in policy MCUP3013 Durable Medical Equipment (DME) Authorization

State of California - Health of Human Services Agency | Department of Health Care Services

INCONTINENCE SUPPLIES MEDICAL NECESSITY CERTIFICATION

SECTION A: Incontinence Provider Information

1. Contact Person	2. Contact Telephone Number	3. Contact Fax Number

SECTION B: Patient Information

4. Patient Name– Last, First, Middle (as appears on card)

5. Medi-Cal ID Number	6. Gender	7. Date of Birth (mm/dd/yy)	8. Age
	Male ☐ Female ☐		

9. Type of Residence
☐ Home ☐ Board and Care ☐ ICF/DD-H ☐ ICF/DD-N ☐ Other _____

SECTION C: Documentation Supporting Medical Necessity

Note: If necessary, include supporting documentation on an attachment

10. Does the patient **meet the Code 1 Restriction**? Yes ☐ No ☐
If yes, indicate the primary and secondary diagnosis name and ICD-10-CM codes.

_____

_____

_____

If no, provide clinical evidence and describe in detail the medical conditions and/or extenuating circumstances to support the medical necessity.

_____

_____

_____

_____

11. Have any **previous treatments** (for example, drug therapy, behavioral techniques, and/or surgical intervention) to manage symptoms of incontinence been tried and failed or been partially successful? Yes ☐ No ☐
If yes, describe treatment(s), treatment results, and patient's responsiveness.

_____

_____

_____

_____

If no, explain reasons why other treatments are not appropriate to decrease or eliminate incontinence.

_____

_____

_____

_____

SECTION C: Documentation Supporting Medical Necessity (Continued)

12. Is this patient **prescribed multiple absorbent product types** to be used during the same time period? Yes ☐ No ☐
If yes, explain in detail the need for multiple varieties of supplies.

13. Does this request include a billing code that **requires prior authorization?** Yes ☐ No ☐
If yes, list billing code(s) and supporting documentation of medical need.

14. Does the patient require a quantity that **exceeds the quantity limits** for any of the supplies needed? Yes ☐ No ☐
If yes, list billing code(s), provide clinical evidence and describe in detail the acute medical condition and/or extenuating circumstances for increased need for additional quantities.

15. Does the patient require supplies (except creams and washes) that **exceed the $165 per month allowable**? Yes ☐ No ☐
If yes, provide a detailed explanation to support the need for supplies exceeding $165 per month.

16. Does this request have an attachment for additional supporting documentation? Yes ☐ No ☐

NOTE: Medical justification must be complete and thorough to process this request. If necessary, provide the supporting documentation and any additional information on an attachment.

SECTION D: List All Prescribed Product Types (For example, briefs, protective underwear, etc.)

17. Complete the table below for the supplies prescribed. Enter the last date of service (DOS) if previously billed.

Billing Code	Product Type	Last DOS	Daily Usage	Unit Cost	Monthly Usage	Monthly Cost	Total Units

18. This prescription is valid for _____ months. **NOTE:** The maximum allowed is 12 months. The physician's signature date below must be within 12 months of the date of service on the claim.

SECTION E: Physician's Attestation, Signature and Date (Physician's Use Only)

By my signature below, I verify that I have physically examined the patient within the last 12 months and certify to the best of my knowledge that the information contained in this form is true, accurate and complete. I have prescribed the items on this form and will maintain a copy of this prescription in the beneficiary's medical record to meet Medi-Cal documentation requirements.

19. Physician's Name	20. Physician's National Provider Identifier

21. Physician's Business Address (number, street)	City	ZIP Code

22. Physician Telephone Number	23. Physician's Signature	24. Date

INCONTINENCE SUPPLIES MEDICAL NECESSITY CERTIFICATION INSTRUCTIONS

SUBMISSION REQUIREMENTS: This form must accompany each Treatment Authorization Request (TAR) and must contain <u>all</u> supplies needed for the time period, not just supplies needing a TAR.

SECTION A: Incontinence Provider Information

1. Enter the name of the individual to contact for TAR questions.
2. Enter the phone number where the contact person can be reached.
3. Enter the fax number to receive information.

SECTION B: Patient Information

4. Enter the patient's last name, first name and middle initial.
5. Enter the Medi-Cal Identification Number.
6. Check the appropriate box.
7. Enter the complete date as 2-digit month, 2-digit day, and 2-digit year.
8. Enter the patient's current age.
9. Check the appropriate box.

SECTION C: Documentation Supporting Medical Necessity

10. – 15. An answer to each question is required. Depending on the response further explanation to support medical justification is required and if needed may be included on an attachment.
    NOTE: Medical justification must be complete and thorough in order to process the request.
16. Indicate if an attachment is included with this form.

SECTION D: List All Prescribed Product Types

17. This table must include **<u>all</u> supplies prescribed** for this patient's use during the number of months covered by this prescription.
    - Billing Code - Enter the HCPCS billing code for each supply item. Refer to the *List of Incontinence Medical Supplies Billing Codes*
    - Product Type – For each billing code enter the corresponding product type name (for example, cream, wash, disposable brief, protective underwear, pad, liner and underpad). Do not list brand name.
    - Last DOS – Enter the last date of service if product type was previously billed.
    - Daily Usage – Enter the estimated number of units the patient will use daily
    - Monthly Usage – Enter the estimated number of units the patient will use monthly.
    - Monthly Cost – Enter the estimated monthly cost for this supply, including markup and sales tax (unit cost multiplied by the monthly usage plus markup and sales tax)
    - Total units – Enter the total number of units for each supply item prescribed (monthly usage multiplied by the total number of months covered by this prescription).
18. Enter the number of months covered by this prescription. The maximum allowed is twelve (12) months.

SECTION E: Physician's Attestation, Signature and Date (Physician's Use Only)

NOTE: This section must be completed by the attending physician. The physician's personal signature in ink and date of signature is required. Signatures stamped, printed or initials are not acceptable.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3104</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Transplant Authorization Process</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/21/2010</td><td colspan="4">Next Review Date: ~~02/14/2025~~02/12/2026
Last Review Date: ~~02/14/2024~~02/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~02/14/2024~~02/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3137 – Palliative Care: Intensive Program (Adult)
D. MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21
E. MCUP3039 – Direct Members
F. MCUP3138 – External Independent Medical Review
G. MCCP2024 – Whole Child Model for California Children's Services (CCS)
H. MCCP2016 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
I. MCCP2030 –Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls
J. MPCR700 – Assessment of Organizational Providers
K. MPPR200 – Provider Contracts

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Center of Excellence (COE): A Medi-Cal-approved transplant program which operates within a hospital setting, is certified and licensed through the Centers for Medicare and Medicaid Services (CMS), and meets Medi-Cal state and federal regulations consistent with 42 CFR, parts 405, 482, 488, 498 and Section 1138 of the Social Security Act (SSA).
B. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status may be based on the member's medical condition, prime insurance, demographics or administrative eligibility status. Direct Members do not require a Referral Authorization Form (RAF) to see a specialist.
C. Organ Procurement and Transplantation Network (OPTN): The OPTN is operated under contract with the Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human Services by the United Network for Organ Sharing (UNOS). OPTN maintains the National Waitlist but only a Transplant Program can register patients on the National Wait list or remove them from the list.
D. Transplant Program: A unit within a hospital that has received approval from CMS to perform transplants for a specific type of organ and is a current beneficiary of the Organ Procurement and

Transplantation Network (OPTN), which is administered by the United Network for Organ Sharing (UNOS).

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

A. The purpose of this policy is to describe the Partnership HealthPlan of California ~~(PHC)~~ treatment authorization process for transplants including the following:

1. Bone Marrow (stem cell)*
2. Heart*
3. Lung*
4. Heart/lung*
5. Liver*
6. Combined liver/kidney*
7. Simultaneous Pancreas/Kidney (SPK)*
8. Pancreas After Kidney (PAK)*
9. Small Bowel (Intestinal) Transplant*
10. Combined liver/small bowel(intestinal)*
11. Kidney+
12. Corneal transplant+
13. Autologous islet cell+
14. Chimeric Antigen Receptor T-Cell (CAR T-cell) therapy

* These transplants can only be approved when performed by a Medi-Cal approved Center of Excellence (COE) as defined in III.A.

+ Programs that perform corneal, autologous islet cell or kidney transplants are not required to be a Medi-Cal approved COE.

VI. POLICY / PROCEDURE:

A. ~~PHC~~Partnership authorizes, refers, and coordinates the delivery of the Medi-Cal Major Organ Transplant (MOT) benefit and all medically necessary services associated with MOTs, including, but not limited to, pre-transplantation assessments and appointments, organ procurement costs, hospitalization, surgery, discharge planning, readmissions from complications, post-operative services, medications[1], and care coordination for transplants. All medically necessary adult and pediatric major organ transplants are covered as outlined in the Medi-Cal Provider Manual, including all updates and amendments to the Provider Manual. The Transplant section of the Medi-Cal Provider Manual is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/8B313A4A-3B84-49DB-B98B-6A51BECCF01C/transplant.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

1. Transplants will only be authorized to be performed in an approved transplant program located within a hospital that meets the Department of Health Care Services' (DHCS) criteria.
2. As noted in V.A. above, certain transplants are only covered when performed by Medi-Cal approved Centers of Excellence (COE).

[1] *Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-for-Service as described in APL 22-012 Revised "Governor's Executive Order N-01-19 regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx" and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/ DHCS contracted pharmacy administrator~~Magellan~~ instead of ~~PHC~~Partnership. Please refer to the State Medi-Cal Rx Education & Outreach page at this website: https://medi-calrx.dhcs.ca.gov/home/education/*

3. Bone marrow transplant programs must have current accreditation by the Foundation for the Accreditation of Cellular Therapy.
4. Major organ transplants for pediatric beneficiaries are required to be performed only in a Special Care Center (SCC) as approved by California Children's Services (CCS). A directory of SCCs can be found here: https://www.dhcs.ca.gov/services/ccs/scc/Pages/SCCType.aspx
5. Total pancreatectomy with autologous islet cell transplantation (TPIAT) is reimbursable by Medi-Cal when the patient has chronic pancreatitis or relapsing acute pancreatitis and meets medical necessity criteria as stated in the Transplants section of the Medi-Cal Provider Manual.
6. Kidney transplants must be performed by transplant programs approved by the Centers for Medicare & Medicaid (CMS) and the program must have current membership in the Organ Procurement and Transplantation Network (OPTN). Patients must meet medical necessity criteria as stated in the Transplants section of the Medi-Cal Provider Manual.
7. CAR T-cell therapy must meet drug-specific Risk Evaluation and Mitigation Strategy (REMS) requirements. For more information, refer to Medi-Cal Provider Manual Guidelines for chemotherapy drugs as Referenced in VII.F.-H. below.

B. Members Age 21 and Over
1. When a ~~member~~ Member is identified as a potential candidate for a transplant, the ~~member~~ Member should be referred to a ~~PHC~~Partnership-contracted Medi-Cal approved Transplant Center for evaluation as described in VI.A. Consistent with ~~PHC~~Partnership policy MCUP3124 Referral to Specialists (RAF) Policy, referrals to contracted specialists are auto-adjudicated and written approval is generated to the requesting primary care provider (PCP) and the specialist within one working day of the receipt of the request (not to exceed 72 hours).
2. Members remain assigned to their primary care provider (PCP) during the evaluation process.
3. Upon completion of the evaluation, if the Transplant Center Team confirms the ~~member~~ Member is appropriate for transplant, the transplant program is responsible for placing the beneficiary on the National Waitlist maintained by The Organ Procurement and Transplantation Network OPTN. A Treatment Authorization Request (TAR) must then be submitted to ~~PHC~~Partnership. The request may be submitted electronically through ~~PHC~~Partnership's online Provider Portal, or by fax to 707-863-4118. The complete medical record including the member's medical and treatment history (including, starting in January 2020, either a palliative care consultation or equivalent documentation of discussion of options, prognosis, goals of care, and completion of advance care planning documents) pertinent lab studies, current condition and treatment, and requested procedure must accompany the TAR.
4. ~~PHC~~Partnership will review the transplant request for medical necessity using the most up-to-date InterQual® criteria and DHCS medical and procedural guidelines. Transplant requests are reviewed by ~~PHC~~Partnership's Chief Medical Officer (CMO) or Physician designee and may be sent for external independent medical review as appropriate.
5. Once the TAR is approved, the member, physician and facility are notified in writing.
6. When the TAR for a transplant is approved, ~~PHC~~Partnership assigns the ~~member~~ Member to a Direct Member status, Health Plan 5, ~~for an initial period of 12 months~~ to ensure continuity of care. Re-evaluation of the continued need for Direct Member status will be reviewed at the end of ~~the~~ 12 ~~-~~ months ~~period.~~or as follows:
   a. Heart transplant recipients are granted H5 for plan lifetime.
   ~~a.~~b. Bone Marrow transplant Members (including CAR T-cell therapy and gene therapy) become eligible for assignment to a PCP two years after receiving the transplant, but may qualify for continued H5 based on continuity of care criteria as detailed in policy MCUP3039 Direct Members.

C. Members Under Age 21
1. For members under age 21, the procedures noted in sections VI.B.1 through VI.B.4 remain the same.

However, these members will also be evaluated for eligibility under the California Children's Services (CCS) program (see VI.C.3 for additional authorization criteria).

2. If the ~~member~~ Member has not already been determined eligible under the CCS program, ~~PHC~~Partnership will work with the member's physician, parents/legal guardians and refer the case to the designated County CCS office for a financial and residential eligibility determination.
3. If the ~~member~~ Member is determined eligible for CCS, ~~PHC~~Partnership will review the transplant request for medical necessity using a combination of the most up-to-date InterQual® criteria as well as the medical and procedural guidelines as directed in the DHCS "Numbered Letters" for CCS (some of which have not been updated for current standards of medical care). Medical Directors may obtain outside expert advice for complex cases or those where the Numbered Letters seem to conflict with current standards of care.
4. Members under age 21 with coverage under CCS are assigned to a ~~PHC~~Partnership Direct Member status called "Whole Child Model" (WCM)[2] and will remain in that status until they reach their 21st birthday, as long as they retain residential, financial and medical eligibility with CCS. This status allows for direct referral to a specialist, without being subject to ~~PHC~~Partnership's Referral Authorization Form (RAF) process. (See policy MCCP2024 Whole Child Model for California Children's Services and MCUP3039 Direct Members).
5. ~~PHC~~Partnership will provide ongoing case management services and continue to coordinate care and transition of services for these members regardless of age, for as long as they remain eligible for coverage under ~~PHC~~Partnership. In the event that a WCM ~~member~~ Membermoves outside of ~~PHC~~Partnership's services area, ~~PHC~~Partnership will collaborate with the receiving county CCS staff to facilitate continuity of care.

D. Donors
1. Per DHCS policy, ~~PHC~~Partnership will cover designated donor related hospital services associated with the transplant, including organ procurement for cadaver organ transplants or living donor care and related transportation expenses, if not covered by other insurance. (see also policy MCCP2016 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) as well as policy MCCP2030 Ancillary Transportation Services: Lodging, Meals, Attendants, Parking and Tolls).

VII. REFERENCES:

A. In compliance with the California Department of Health Care Services (DHCS) contract
B. In compliance with DHCS "Numbered Letters" for California Children's Services (CCS)
C. InterQual® Criteria
D. Medi-Cal Provider Manual/ Guidelines: Transplants
E. Medi-Cal Provider Manual/ Guidelines: Surgery: Eye and Ocular Adnexa
F. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs A~~-D~~ P~~p~~olicy
~~F.~~G. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs B~~E-O~~ P~~p~~olicy
H. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs ~~P-Z~~C P~~p~~olicy
I. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs D Policy
J. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs E-H Policy
K. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs I-L Policy
L. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs M Policy

[2] ~~In PHC~~Partnership's service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in PHC~~Partnership~~'s service area are participants in the State's CCS program and are not participants in PHC~~Partnership~~'s Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.

M. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs N-O Policy
N. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs P-Q Policy
O. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs R-S Policy
~~G.~~P. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs T-Z Policy
~~H.~~Q. Title 42 Code of Federal Regulations (CFR) parts 405, 482, 488, 498
~~I.~~R. Section 1138 of the Social Security Act (SSA).
~~J.~~S. DHCS APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (10/18/2021) Attachment 2 Major Organ Transplant Requirements. (*Revised* 10/14/2022)
~~K.~~T. DHCS APL 22-012 Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx (*Revised* 12/30/2022)
~~L.~~U. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (05/18/2022)

VIII. DISTRIBUTION:
A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:
01/18/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 09/11/19; 09/09/20; 02/10/21; 02/09/22; 02/08/23: 02/14/24; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by ~~PHC~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Policy/Procedure Number: MCUP3104			**Lead Department: Health Services** Business Unit: Utilization Management
Policy/Procedure Title: Transplant Authorization Process			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/21/2010		**Next Review Date: 02/14/202502/12/2026** **Last Review Date: 02/14/202402/12/2025**	
Applies to:	☒ **Medi-Cal**		☐ **Employees**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCUP3113			**Lead Department: Health Services** **Business Unit: Utilization Management**	
Policy/Procedure Title: Telehealth Services			☒**External Policy** ☐ **Internal Policy**	
Original Date: 03/14/2012		**Next Review Date:** ~~11/08/2024~~02/12/2026 **Last Review Date:** ~~11/08/2023~~02/12/2025		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** 02/12/2025	

I. RELATED POLICIES:

A. MCUP3124 - Referral to Specialists (RAF) Policy
B. MCUP3052 - Medical Nutrition Services
C. MCUP3028 - Mental Health Services
D. MCUP3101 - Screening and Treatment for Substance Use Disorders
E. MCUP3137 - Palliative Care: Intensive Program (Adult)
F. MCUP3140 - Palliative Care: Pediatric Program for Members Under the Age of 21
G. MPCR200 - Credentials Committee and CMO Credentialing Program Responsibilities
H. MCND9006 - Doula Services Benefit
I. MCCP2033- Community Health Worker (CHW) Services Benefit
~~F.~~J. MCCP2032- CalAIM Enhanced Care Management (ECM)

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Claims

III. DEFINITIONS:

A. Asynchronous store and forward means the transmission of a patient's medical information from an originating site to the health care provider at a distance without the presence of the patient.
B. Distant site means a site where a health care provider who provides health services is located while providing these services via telecommunications system ~~Health care provider means a person who is licensed by the State of California Department of Health Care Services (DHCS) and a Medi-Cal certified provider.~~
C. E-Consult means an asynchronous electronic consultation service between health care providers to coordinate multidisciplinary case review, advisory opinion, and recommendations of care for complicated symptoms or illnesses.
D. E&M: Evaluation and Management
E. Health care provider means a person who is licensed by the State of California Department of Health Care Services (DHCS) and a Medi-Cal certified provider.
F. Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
~~A. Telehealth means the mode of delivering health care and public health services utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care~~

~~management and self-management of patients at a distance from health care providers.~~

~~B.~~A. ~~Health care provider~~ means a person who is licensed by the State of California Department of Health Care Services (DHCS) and a Medi-Cal certified provider.

~~C.~~G. Originating site means the site where a patient is located at the time health services are provided via a telecommunications system or where the asynchronous store and forward services originates.

~~D. Distant site means a site where a health care provider who provides health services is located while providing these services via telecommunications system.~~

~~E.~~H. Synchronous interaction means a real-time interaction between a patient and health care provider located at a distant site.

I. Telehealth means the mode of delivering health care and public health services utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health care providers.

~~F.~~A. ~~Asynchronous store and forward means the transmission of a patient's medical information from an originating site to the health care provider at a distance without the presence of the patient~~

~~G. E-Consult means an asynchronous electronic consultation service between health care providers to coordinate multidisciplinary case review, advisory opinion, and recommendations of care for complicated symptoms or illnesses.~~

~~H. Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.~~

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The goal of telehealth is to improve both healthcare access and quality of health services through ~~the use of~~ information and telecommunications technologies. The purpose of this policy is to define the telehealth services available to Partnership HealthPlan of California ~~(PHC)~~Members and the~~ir~~ general policies for reimbursement of those services ~~policies~~.~~In 1996, Medicare initially approved limited coverage for telemedicine services. In the same year, the State of California passed the Telemedicine Development Act of 1996 governing the delivery of health care services through Telemedicine and authorizing terms and conditions of reimbursement of Telemedicine services under Medi-Cal. In 2005, California broadened the definition of telemedicine services to include store and forward telemedicine consults for teleopthalmology and teledermatology. Most recently, the State approved AB 415 the Telehealth Advancement Act of 2011 that allows for:~~

~~• The provision of a broader range of telehealth services~~
~~• The expansion of telehealth providers to include all licensed healthcare professionals~~
~~• The expansion of telehealth settings to include physician offices, hospitals, clinics and home settings and other sites~~
~~• The ability of California hospitals to establish medical credentials for telehealth providers more easily~~

~~The Telehealth Advancement Act of 2011 does not limit the type of settings where telehealth services are provided to patients. Telehealth services may be provided at a physician office, clinic setting, hospital, skilled nursing facility, residential care setting or patient home or other setting and must be in compliance with all laws regarding the confidentiality of health care information and a patient's rights to his or her medical information. There is no longer a need to document a justification for use of telehealth services instead of in-person services. Aside from this, services provided by telehealth must still meet state and federal guidelines for "medical necessity" and the documentation should support this.~~

Policy/Procedure Number:		Lead Department: Health Services Business Unit: Utilization Management
Policy/Procedure Title: Telehealth Services		☒ External Policy ☐ Internal Policy
Original Date: 03/14/2012	Next Review Date: 11/08/202402/12/2026 Last Review Date: 11/08/202302/12/2025	
Applies to:	☒ Medi-Cal	☐ Employees

VI. POLICY / PROCEDURE:

A. ~~General~~Telehealth Services

~~Historical Context:~~

~~In 1996, Medicare initially approved limited coverage for telemedicine services. In the same year, the State of California passed the Telemedicine Development Act of 1996 governing the delivery of health care services through Telemedicine and authorizing terms and conditions of reimbursement of Telemedicine services under Medi-Cal. In 2005, California broadened the definition of telemedicine services to include store and forward telemedicine consults for teleopthalmology and teledermatology.~~

~~Most~~More ~~recently, the State approved AB 415, the Telehealth Advancement Act of 2011 that allows for:~~

- ~~The provision of a broader range of telehealth services~~
- ~~The expansion of telehealth providers to include all licensed healthcare professionals~~
- ~~The expansion of telehealth settings to include physician offices, hospitals, clinics and home settings and other sites~~
- ~~The ability of California hospitals to establish medical credentials for telehealth providers more easily~~

~~The Telehealth Advancement Act of 2011 does not limit the type of settings where telehealth services are provided to patients.~~

~~Telehealth services may be provided at a physician office, clinic setting, hospital, skilled nursing facility, residential care setting or patient home or other setting and must be in compliance with all laws regarding the confidentiality of health care information and a patient's rights to his or her medical information.~~

~~There is no longer a need to document a justification for use of telehealth services instead of in-person services.~~

1. ~~Aside from this,~~ Sservices provided by telehealth must still meet state and federal guidelines for "medical necessity" ~~-~~and the documentation should support this.

2. ~~This policy defines key telemedicine/telehealth terms, PHC telehealth covered benefits and, reimbursement policies. PHC~~Partnership fully supports the advancement of telehealth services in our region as a means of improving access and quality of care to ~~member~~Members,, as well as providing expert advice and specialty consultation to primary care providers (PCPs) in the ~~PHC~~Partnership network.
   a. Current ~~PHC~~Partnership referral and authorization requirements apply to telehealth services per policy MCUP3124 Referral to Specialists (RAF) Policy.
   b. Telemedicine services may be used to provide Non-Specialty Mental Health Services to ~~PHC~~Partnership ~~member~~Members. Such services are provided through ~~PHC~~Partnership's ~~contracted~~ delegated Managed Behavioral Healthcare ~~Managed Services~~ Oorganization~~(s)~~. See policy MCUP3028 Mental Health Services for additional information.
   Substance Use Disorder treatment services may be provided via telemedicine through ~~PHC~~Partnership's Wellness & Recovery Program. See policy MCUP3101 Screening and Treatment for Substance Use Disorders for additional information.
   c.

B. Telehealth Services Models

1. ~~Traditional~~ Synchronous Telehealth Services ~~and Settings~~
   In this model, a licensed provider is present at the telehealth Originating Site when a patient is connected with a distant provider of health services through audio-video equipment on a real-time basis. This model is commonly used between specialty centers such as University of California (UC)

San Francisco or UC Davis with outlying physician offices or community health centers.

2. Synchronous Patient to Provider Telehealth Services
   This model connects a single provider (primary care or specialty provider) to a patient using audio-visual equipment on a real-time basis. The patient can be in a health facility, residential group home, private residence or other setting, provided that the appropriate equipment is used.
3. Asynchronous Telehealth Services~~/ and Settings~~ ("Store and Forward" and~~/~~ E-Consult)~~s~~
   ~~This~~In the asynchronous telehealth model, ~~connects~~ a patient's medical information is electronically forwarded to ~~with~~ a distant provider for review, ~~of radiology, electrocardiography, ophthalmology, dermatology or certain optometry services~~ using audio-video equipment, but not on a real-time basis. The case may be reviewed as follows:
   a. Store and Forward: ~~Generally, an I~~images, videos, photos, labs, and/or other relevant patient information are electronically ~~or picture is taken and~~ forwarded to ~~the~~a specialty provider ~~to~~ for review at a later time. (Applies to ~~-~~radiology, electrocardiography, ophthalmology, dermatology or certain optometric procedures.) ~~This also includes specialty services provided via~~
   b. E-Consult~~, or~~ (electronic consultation):~~s, which consist of~~ In an electronic exchange of information, healthcare providers at the originating site transmit patient information to the distant site to coordinate multidisciplinary case review for complicated symptoms or illnesses, without the patient being present in real time. ~~through the E-Consult platform and may include images or photos, labs, and other relevant patient information.~~

~~a. Patients receiving teledermatology or teleophthalmology services by store and forward must be notified of the right to interactive communication with the distant specialist if requested.~~
~~1) If requested, the communication may occur at the time of the consultation or within 30 calendar days of the patient's notification of the results of the consultation.~~
~~2)~~1)~~E-consult telehealth services fall under the auspice of store and forward services and provide the ability for health care providers at the originating and distant site to review medical information for complicated symptoms or illnesses without the patient being present in real time.~~ The following codes should be used for E-Cconsults: 99451 for the specialist site and 99452 for the referring (originating) site, noting the minimum time requirement for 99451 ~~are~~is 5 minutes, and the minimum time requirement~~s~~ for 99452 is 16 minutes.
~~3)~~2)A health care provider at a distant site may bill for an E-consult with the appropriate Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) code when the benefits or services delivered meet the procedural definition and components of the national CPT/HCPCS code as defined by the American Medical Association (AMA) or any other extended guideline described in the Medi-Cal provider manual.

~~B. G. Consent~~

C. Consent for Telehealth Services

1. Prior to the delivery of health care services via synchronous telehealth, the healthcare provider at the ~~presentation~~originating site must verbally inform the patient that telehealth may be used and obtain written or verbal consent from the patient for this use.
   a. The verbal consent must be documented in the patient's medical record.
   b. Providers are required to share additional information with Partnership Members such as:
      1) Right to in-person services
      2) Voluntary nature of consent
      3) Availability of transportation to access in-person services
      4) Limitations/risks of receiving services via telehealth
      5) Availability of translation services
2. Synchronous telehealth services can be provided to ~~PHC~~Partnership members by any

PHCPartnership credentialed health-care provider with the Mmember's written or verbal consent, as documented in the patient's medical record.

D. Confidentiality

1. All federal and state laws regarding the confidentiality of health care information and a patient's rights to his or her medical information apply to telehealth services.

C. New Patient Relationships

E.

a. All Providers may establish new patient relationships via synchronous video Telehealth visits.

a.

b. All Providers may establish new patient relationships via audio-only synchronous interaction only if one or more of the following criteria applies:

1) Healthcare services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, and intimate partner violence.

2) The patient requests audio-only modality.

3) The patient attests they do not have access to video.

4)3)

F. Confidentiality

1. All federal and state laws regarding the confidentiality of health care information and a patient's rights to his or her medical information apply to telehealth services.

Credentialing of Providers of Who Provide Telehealth Services to PHCPartnership Members in a Hospital Setting

1. Licensed health-care providers providing telehealth services to hospitalized Partnership HealthPlan Mmembers, from outside thea hospital setting, need tomust be a Medi-Cal certified providers in the State of California and a qualified providers credentialed through Partnership HealthPlan, or through an organization with delegated authority for credentialing., , as approved by the Partnership HealthPlan Credentials Committee.
2. The governing body of the hospital whose patients are receiving telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant site hospital or telehealth entity, as described in Sections 482.12, 482.22 and 485.616 of Title 42 of the Code of Federal Regulations.

G. Required Equipment

1. The audio-video telemedicine system used, must, at a minimum, have the capability of meeting the procedural definition of the CPT/HCPCS code for the benefits or services being deliveredprovided through telehealth. The telecommunication equipment must be of a quality to adequately complete all necessary components to document the level of service for the CPT/HCPCS code billed.

1.

H. Reimbursement for Telehealth Services

I. There are three main models of telehealth services available to PHC members.

J. The first, called "Traditional Synchronous Telehealth Services" connects the patient with a distant provider of health services through audio-video equipment on a real-time basis. This model is commonly used between specialty centers such as University of California (UC) San Francisco or UC Davis with outlying physician offices or community health centers.

K. The second model, called "Asynchronous Telehealth Services" or the "Store and Forward" model connects a patient with a distant provider of radiology, electrocardiography, ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally, an image or picture is taken and forwarded to the specialty provider to review at a later time. This also includes specialty services provided via E-Consult, or electronic consultations, which consist

~~of an electronic exchange of information through the E-Consult platform and may include images or photos, labs, and other relevant patient information.~~

~~L. The third model called "Synchronous Patient to Provider Telehealth Services" connects a single provider (primary care or specialty provider) to a patient using audio-visual equipment on a real-time basis. The patient can be in a health facility, residential group home or private residence or other setting, provided the appropriate equipment is used. The reimbursement terms for each of the three models are summarized below:~~

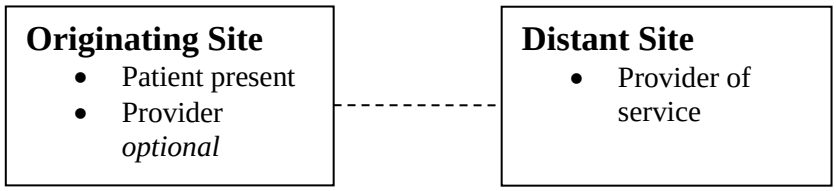
~~M.~~H. Reimbursement for Telehealth Services

Unless otherwise agreed to by ~~PHC~~Partnership and provider, ~~PHC~~Partnership will reimburse providers at the same rate ~~,~~ whether a covered service is provided in-person or through Telehealth, ~~if~~ when the service is the same regardless of the modality of delivery, as determined by the Provider's description of the service on the claim. (

Applies to both video and audio-only visits as medically appropriate.

The reimbursement terms for each of the three models are summarized below:

1. Reimbursement for Traditional Synchronous Telehealth Services



a. If a licensed provider is also present at the telehealth Originating Site with the patient and a progress note is generated by the originating provider, the visit is reimbursable.
   1) The scope of the interaction with the originating provider should be documented in the progress notes that is distinct from those provided by the Distant Site and will be the basis of the Evaluation and Management (E&M) and other CPT/HCPCS code(s) billed.
   2) If an E&M code is included, the transmission cost fees may be billed. No modifier is needed at the Originating Site.

b. Health care providers (with the exception of Federally Qualified Health Centers [FQHCs], Rural Health Centers [RHCs] and ~~IHS~~Tribal Health Centers as noted below) are required to document Place of Service Codes on claims, which indicate that services were provided or received through a telecommunications system. A place of service (POS) code is a two-digit code that indicates the location where a medical service was provided. The Centers for Medicare & Medicaid Services (CMS) maintains the POS code set, which is used by healthcare providers and insurance companies to determine the correct payment amount for a service
   1) Place of Service Code 02 indicates that telehealth services were provided to a patient in a location other than their home.
   2) Place of Service Code 10 indicates that the patient was in their home while receiving telehealth services.
   3) The Place of Service Code requirement is not applicable for FQHCs, RHCs or ~~Indian Health Services (IHS)~~Tribal Health Centers as noted in the Originating Site table below.

c. Each telehealth provider must be licensed in the State of California (if a licensure pathway is available), enrolled as a Medi-Cal Provider or Non-Physician Medical Practitioner, and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and be located in California or a border community.

d. Partnership covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:
   1) The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment
   2) The services delivered via telehealth meet the procedural definition and components in the CPT-4 or HCPCS code(s) associated with the covered service; and
   3) The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

e. Certain types of services *cannot* be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service.

f. An ~~Federally Qualified Health Center (~~FQHC~~)~~/ ~~Rural Health Center (~~RHC~~)~~/ Tribal H~~h~~ealth ~~site~~Center may choose to sub-contract with a specialist~~t~~ and pay them directly. Under these circumstances, the FQHC/ RHC/ Tribal Health Center would bill for the originating site and the specialty service on two separate claims.
   1) Designated telehealth specialist providers Referral Authorization Form (RAF) requirements vary, see policy MCUP3124 Referral to Specialists (RAF) Policy.
   2) The Partnership system would need to be set up for the specific specialty, and if not, the ~~Provider Relations~~Network Services Department should be contacted.

Billing guidelines for Originating Site Providers (Traditional Synchronous Telehealth Services):

Originating Site (Traditional Synchronous Telehealth Services)	
Service	**Code(s)**
Site facility fee	Q3014 (once per day, per patient, same provider)
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient, per day, same provider)*
Licensed provider fee (*if present*)	E&M codes 99201 – 99205; 99211 ~~–~~ 99215, T1015 (for health centers) and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.

***~~Note that Federally Qualified Health Centers (~~FQHCs~~)~~/ ~~Rural Health Centers (~~RHCs~~)~~/ ~~Indian Health Services (IHS)~~Tribal Health Centers cannot bill for site fee or transmission charges. These charges are included in their FQHC/RHC Prospective Payment System (PPS) rate or the IHS Memorandum of Agreement (MOA) rate.

~~a. If a Licensed provider also is present at the telehealth Originating Site with the patient present and a progress note is generated by the originating provider, the visit is reimbursable. The scope of the interaction with the originating provider should be documented in the progress note that are distinct from those provided by the Distant Site and will be the basis of the Evaluation and~~

~~Management (E&M) and other CPT code(s) billed. If an E&M code is included, the transmission cost fees may be billed. No modifier is needed at the Originating Site.~~

~~b. Health care providers are required to document place of service Code 02 on the claim, which indicates that services were provided or received through a telecommunications system. The Place of Service Code 02 requirement is not applicable for FQHCs, RHCs or Indian Health Services (IHS).~~

Billing guidelines for Distant Site Providers (Traditional Synchronous Telehealth Services):

Distant Site (Traditional Synchronous Telehealth Services)	
Service	**Code(s)**
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient, per day, same provider)
Initial hospital care or subsequent hospital care, critical care (new or established patient)	Inpatient hospital: 99221 – 99233 Critical care: 99291 or G0508; 99292 or G0509
Extended Inpatient Care	99418
Consultations: Office or other outpatient (initial or follow-up) Inpatient, and confirmatory	99242 – 99245; 99252 - 99255
Genetic Counseling	S0265
Nutrition Counseling per ~~PHC~~Partnership Guidelines (See Policy MCUP3052)	97802, 97803, 97804, G0108, G0109
ACE Screenings	G9919, G9920
Mental Health Assessment (by Non-Physician)	H0031 (may be billed up to 1 hour, once per year)
Perinatal Educational Counseling (by Partnership approved Perinatal Services Providers/Practices)	Z6400-Z6414 Z6500 Z6200-Z6208 Z6300-Z6308
Other Covered Procedures that can be provided by telemedicine	All CPT/HCPCS codes are potentially allowed if they meet requirements as described in section VI.H.1.~~e.and~~ d. of this policy.
Procedures that are Excluded from Telehealth:~~Other Covered Procedures that can be provided by telemedicine*~~	~~All CPT codes are potentially allowed if they meet requirements as noted*~~ **~~Except for these~~These Codes are Excluded~~codes**:~~:** **Anesthesia:** 00100 - 01999 and 99100 - 99157~~;~~ **~~Drug Administration and Vaccination:~~** **Surgery:** 10021 - 69990~~;~~ **Speech/Occupational/Physical Therapy:** 96101 to 97546, 97750 - 97799, 97161 - 97164, and 98970 - 98972~~;~~vie **Wound care:** 97597 - 97610; **Acupuncture, osteopathic manipulation, chiropractic manipulation**: 97810 - 98943 **Refer to section VI.~~HG~~.1.~~ed~~. of this policy for other codes that may be excluded.**

Virtual/Telephonic Communications (Brief video or phone visit with a patient or a provider in office and patient remote from office [in lieu of office visit])	**G2012 -** Brief virtual/telephonic communication with another practitioner or with a patient (5-10 minutes of medical discussion. **Place of Service Code "02" -** must be documented on the claim to indicate that services were provided through a telecommunications system in a location other than the patient's home. **Place of Service Code "10" -** must be documented on the claim to indicate that services were provided through a telecommunications system while the patient was in their home.~~.~~
Required Modifier - video	95 modifier required for all CPT-Codes except Transmission T1014 Cost code and G2012 code.
Required Modifier – audio-only	93 modifier required for all CPT-Codes except Transmission T1014 Cost code and G2012 codes.**~~*~~

~~c. * Each telehealth provider must be licensed in the State of California, enrolled as a Medi-Cal Provider or Non-Physician Medical Practitioner, and must reside in California (or a border community) or affiliated with a Medi-Cal enrolled Provider group. PHC covered services, identified by Current Procedural Terminology 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:~~

~~1) 1. The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;~~

~~2) 2. The services delivered via telehealth meet the procedural definition and components in the CPT-4 or HCPCS code(s) associated with the covered service; and~~

~~3) 3. The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.~~

~~**Certain types of services *cannot* be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service.~~

**~~*~~ Effective ~~no sooner than~~ January 1, 2024, all Providers furnishing applicable Covered Services via audio-only synchronous interactions must also offer those same services via video synchronous interactions ~~as~~ to preserve Member choice.

~~**Note:** A Federally Qualified Health Center (FQHC)/ Rural Health Center (RHC)/Tribal health site may choose to sub-contract with a specialist and pay them directly. Under these circumstances, the FQHC/RHC would bill for the originating site and the specialty service on two separate claims. Designated telehealth specialist providers Referral Authorization Form (RAF) requirements vary, see policy MCUP3124 Referral to Specialists (RAF) Policy. The PHC system would need to be set up for the specific specialty and if not, the Provider Relations Department should be contacted.~~

2. Reimbursement for Synchronous: Provider to Patient Telehealth Services

~~Telehealth Advancement Act of 2011 allows for telehealth services to be provided between a qualified provider and patient at a distant location. The location may be a health facility, residential home, patient's home or other location.~~

Originating Site - Patient Location
- Health facility
- Residential group home
- Patient home
- Other location

Provider Site
- Patient *NOT* present
- Options:
  - Provider Site
  - Other location

~~S)~~ .

Billing Guidelines for the Provider Site (Synchronous: Provider to Patient Telehealth Services):

Provider Site	
Service	**Code(s)**
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient, per day, same provider)
Licensed provider fee (*if present*)	E&M codes 99201 – 99205; 99211 – 99215, T1015 and other non-excluded codes.
Nutrition Counseling (per ~~PHCPartnership Guidelines (See~~ p~~P~~olicy MCUP3052 Medical Nutrition Services)	97802, 97803, 97804, 99539
~~**Other Covered Procedures that can be provided by telemedicine***~~ ~~(* *as defined on page 5 above*)~~	~~**Speech/Occupational/Physical Therapy (limited use by PT/OT/ST professionals):**~~ ~~G2061 – G2062~~ ~~A Treatment Authorization Request (TAR) form is required. Codes G2061 – G2062 must be billed with modifier 95 for telemedicine as well as one of the allowable modifiers GN (for speech therapy services), GO (for occupational therapy services) or GP (for physical therapy services). Maximum frequency of 20 per month of any code.~~
Required Modifier	95 modifier required for all CPT-Codes except Transmission Cost codes

~~**Billing Guidelines for the Provider Site:**~~

~~A licensed provider who provides E&M services for a patient utilizing telehealth technology to access the provider's office may submit claims for this service using the E&M code, without the modifier. The contracted arrangements for primary care providers and specialty providers continue to apply. T1014 Transmission Cost fee may also be billed.~~

~~Non-licensed health care personnel such as doulas and Community Health Workers may provide telemedicine services as noted in this policy.~~
~~Enhanced Care Management services may be provided via telemedicine. Please see policy MCCP2032.~~
~~Palliative Care services may be provided via telemedicine. Please see policy MCUP3137 (adults) and MCUP3140 (pediatrics).~~

3. Reimbursement for Asynchronous Telehealth Services (Store and Forward and E-Consult)
~~for Teleophthalmology, Teleoptometry, Teledermatology, asynchronous Radiology, and E-Consult Program Services~~

Originating Site		Distant Site
• Patient present • Provider *optional*	Information stored and forwarded to Distant Site	• Provider of service

a. Asynchronous telehealth visits are reimbursable if a licensed provider is also present at the telehealth Originating Site, with the patient present, and a progress note is generated by the originating provider.
b. The scope of the interaction with the originating provider should be documented in the progress note, and will be the basis of the CPT code(s) used. If a CPT code is included, the originating site fee and the transmission cost fees may still be billed. No modifier is needed.
c. Health care providers (with the exception of FQHCs, RHCs, and ~~IHS~~Tribal Health Centers as noted below) are required to document P~~p~~lace of S~~s~~ervice C~~c~~ode~~s 02~~ on the claim, which indicate~~s~~ that services were provided or received through a telecommunications system.~~–~~ A place of service (POS) code is a two-digit code that indicates the location where a medical service was provided. The Centers for Medicare & Medicaid Services (CMS) maintains the POS code set, which is used by healthcare providers and insurance companies to determine the correct payment amount for a service.
    1) Place of Service Code 02 indicates that telehealth services were provided to a patient in a location other than their home.
    2) Place of Service Code 10 indicates that the patient was in their home while receiving telehealth services.
    ~~1)~~ The ~~The~~ Place of Service Code ~~02~~ requirement is not applicable for FQHCs, RHCs or ~~Indian Health Services (IHS)~~Tribal Health ~~Services~~Centers as per "~~VI.G.3.~~c." below.
    3)
~~d.~~
e. ~~If a Licensed provider also is present at the telehealth Originating Site, with the patient present and a progress note is generated by the originating provider, the visit is reimbursable as a visit. The scope of the interaction with the originating provider should be documented in the progress note, and will be the basis of the CPT code(s) used. If a CPT code is included, the originating site fee and the transmission cost fees may still be billed. No modifier is needed.~~
~~f.~~
~~g.~~d. ~~Note:~~ Originating site and transmission fee restrictions and billing rules are not applicable for FQHCs, RHCs or ~~IHS~~Tribal Health Centers. Services provided through telehealth are subject to the same program restrictions, limitations and coverage that exist when the service is provided

in-person. For policy information specific to FQHCs, RHCs, or ~~IHS~~Tribal Health Centers, please see the Medi-Cal provider manual.

Billing guidelines for Originating Site Providers (Asynchronous Telehealth Services):

Originating Site (Asynchronous Telehealth Services)	
Service	**Code(s)**
Site facility fee	Q3014
Licensed provider fee (*if present*)	E&M codes 99201 – 92205; 99211- 99215; T1015, and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider, not on the excluded list.

~~h.~~

~~i.~~ Special Billing Guidelines for Asynchronous Retinal Photography - Originating Site Providers:

~~j.~~e. If a provider uses asynchronous telehealth for eye exam screenings through the use of a retinal camera located at the originating site, special billing guidelines apply~~,~~ when the originating site is paying the specialist directly for reading the results of the retinal photographs. A licensed provider does not need to be present for retinal photography service to be reimbursable. If no provider is present at visit, bill using the following CPT codes:

Originating Store and Forward Site (Retinal Photography)	
Service	**Code**
Retinal photography with interpretation for services provided by optometrists or ophthalmologists	92250 (Do not use modifier)
OR	
Remote imaging for detection of retinal disease with analysis and report under physician supervision, unilateral or bilateral	92227 (Do not use modifier)
Site facility fee	Q3014

1) If provider is present at visit, E&M codes can also be billed as noted in the chart above for "Originating Site (Asynchronous Telehealth Services)~~usual~~." The scope of the interaction with the originating provider should be documented in the progress note. The originating site fee and the transmission cost fees may still be billed. No modifier is needed.

Billing Guidelines for Distant Store and Forward Site Providers (Asynchronous Telehealth Services):

Distant Store and Forward Site

Policy/Procedure Number:		Lead Department: Health Services Business Unit: Utilization Management
Policy/Procedure Title: Telehealth Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/14/2012	**Next Review Date: 11/08/202402/12/2026** **Last Review Date: 11/08/202302/12/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

Service	Code(s)
Office consultation, new or established patient Follow up hospital visit	99242 – 99243 99231 – 99233
Remote evaluation of recorded video and/or images submitted by the patient.	**G2010 –** Remote evaluation of recorded video and/or images submitted by an established patient including interpretation, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an E&M service or procedure
Retinal photography with interpretation for services provided by optometrists or ophthalmologists (should not be used if originating site is submitting claims with this code).	92250
Required Modifier:	All asynchronous, store-and-forward services are billed with a "GQ" modifier

~~k.~~ Special Billing Guidelines for Asynchronous E-Consult service - Distant Site Providers:

f.

~~1)~~ In order to bill for E-Consults, t~~T~~he health care provider at the distant site (consultative provider) must create and maintain the following:

1)

~~a) Create and maintain~~A ~~-~~record of the review and analysis of the transmitted medical information with written documentation of date~~a~~ of service and time spent (between 5 - 30 minutes) and

a)

~~1) Record of preparing a~~A written report of case findings and recommendations with conveyance to the originating site

b)

~~2)~~ The health care ~~Record of maintenance of transmitted medical records in patient's medical record.~~

~~3)~~2) p~~P~~rovider at the distant site (consultant) who~~s~~ meets Medi-Cal standards may bill for E-Consult services provided using the following CPT code in conjunction with modifier "GQ":

Distant Store and Forward Site (E-Consult)	
Service	**Code**
E-Consult, electronic consultation	99451
Required Modifier:	"GQ" modifier

3) In some cases, the originating site may bill for Store and Forward (E-Consults) if at least 16 minutes are required to complete the E-Consult.

Originating Store and Forward Site (E-Consult)	
Service	**Code**
E-Consult, electronic consultation	99452

Required Modifier:	"GQ" modifier

I. Exclusions
1. ~~PHC~~Partnership does not cover communication between providers outside that described ~~above~~ in this policy as E-Consult.
~~1.~~2. ~~PHC~~Partnership does not cover patient - provider communication via email, text, or written communication.
~~2.~~3. Video communication of poor resolution and phone communication are only covered if they meet the criteria stated in section VI.F. and in the chart labeled "Billing Guidelines for Distant Site Providers (Traditional Synchronous Telehealth Services)" in section VI.H.1~~L. above~~.

VII. REFERENCES:
A. Medi-Cal Provider Manual: Medicine: Telehealth ~~-~~(*medne tele*); Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) *(rural)*; Tribal Federally Qualified Health Centers *(tribal fqhc)*; Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics *(ind health)*
B. Title 42 of the Code of Federal Regulations Sections 482.12, 482.22 and 485.616
~~B.~~C. Welfare and Institutions Codes (WIC) § 14132.725
~~C.~~D. Department of Health Services (DHCS) All Plan Letter (APL) 23-007 Telehealth Services Policy (4/10/2023)

VIII. DISTRIBUTION:
A. ~~PHC~~Partnership Provider Manual
B. ~~PHC~~Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:
3/14/12, 2/18/15; 01/20/16; 04/20/16; 09/21/16; 9/20/17; *10/10/18; 08/14/19; 02/12/20; 01/13/21; 01/12/22; 01/11/23; 11/08/23; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by ~~PHC~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership~~'s~~ authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3113</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Telehealth Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 03/14/2012</td><td colspan="4">Next Review Date: 02/12/2026
Last Review Date: 02/12/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 02/12/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3124 - Referral to Specialists (RAF) Policy
B. MCUP3052 - Medical Nutrition Services
C. MCUP3028 - Mental Health Services
D. MCUP3101 - Screening and Treatment for Substance Use Disorders
E. MCUP3137 - Palliative Care: Intensive Program (Adult)
F. MCUP3140 - Palliative Care: Pediatric Program for Members Under the Age of 21
G. MPCR200 - Credentials Committee and CMO Credentialing Program Responsibilities
H. MCND9006 - Doula Services Benefit
I. MCCP2033- Community Health Worker (CHW) Services Benefit
J. MCCP2032- CalAIM Enhanced Care Management (ECM)

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Claims

III. DEFINITIONS:

A. Asynchronous store and forward means the transmission of a patient's medical information from an originating site to the health care provider at a distance without the presence of the patient.
B. Distant site means a site where a health care provider who provides health services is located while providing these services via telecommunications system
C. E-Consult means an asynchronous electronic consultation service between health care providers to coordinate multidisciplinary case review, advisory opinion, and recommendations of care for complicated symptoms or illnesses.
D. E&M: Evaluation and Management
E. Health care provider means a person who is licensed by the State of California Department of Health Care Services (DHCS) and a Medi-Cal certified provider.
F. Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
G. Originating site means the site where a patient is located at the time health services are provided via a telecommunications system or where the asynchronous store and forward services originates.
H. Synchronous interaction means a real-time interaction between a patient and health care provider located at a distant site.

I. Telehealth means the mode of delivering health care and public health services utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health care providers.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The goal of telehealth is to improve both healthcare access and quality of health services through information and telecommunications technologies. The purpose of this policy is to define the telehealth services available to Partnership HealthPlan of California Members and the general policies for reimbursement of those services.

VI. POLICY / PROCEDURE:

A. Telehealth Services
   1. Services provided by telehealth must still meet state and federal guidelines for "medical necessity" and the documentation should support this.
   2. Partnership fully supports the advancement of telehealth services in our region as a means of improving access and quality of care to Members,, as well as providing expert advice and specialty consultation to primary care providers (PCPs) in the Partnership network.
      a. Current Partnership referral and authorization requirements apply to telehealth services per policy MCUP3124 Referral to Specialists (RAF) Policy.
      b. Telemedicine services may be used to provide Non-Specialty Mental Health Services to Partnership Members. Such services are provided through Partnership's delegated Managed Behavioral Healthcare Organization. See policy MCUP3028 Mental Health Services for additional information.
      c. Substance Use Disorder treatment services may be provided via telemedicine through Partnership's Wellness & Recovery Program. See policy MCUP3101 Screening and Treatment for Substance Use Disorders for additional information.

B. Telehealth Services Models
   1. Synchronous Telehealth Services
      In this model, a licensed provider is present at the telehealth Originating Site when a patient is connected with a distant provider of health services through audio-video equipment on a real-time basis. This model is commonly used between specialty centers such as University of California (UC) San Francisco or UC Davis with outlying physician offices or community health centers.
   2. Synchronous Patient to Provider Telehealth Services
      This model connects a single provider (primary care or specialty provider) to a patient using audio-visual equipment on a real-time basis. The patient can be in a health facility, residential group home, private residence or other setting, provided that the appropriate equipment is used.
   3. Asynchronous Telehealth Services ("Store and Forward" and E-Consult)
      In the asynchronous telehealth model, a patient's medical information is electronically forwarded to a distant provider for review, but not on a real-time basis. The case may be reviewed as follows:
      a. Store and Forward: Images, videos, photos, labs, and/or other relevant patient information are electronically forwarded to a specialty provider for review at a later time. (Applies to radiology, electrocardiography, ophthalmology, dermatology or certain optometric procedures.)
      b. E-Consult (electronic consultation):In an electronic exchange of information, healthcare providers at the originating site transmit patient information to the distant site to coordinate multidisciplinary case review for complicated symptoms or illnesses, without the patient being present in real time.

1) The following codes should be used for E-Consults: 99451 for the specialist site and 99452 for the referring (originating) site, noting the minimum time requirement for 99451 is 5 minutes, and the minimum time requirement for 99452 is 16 minutes.
2) A health care provider at a distant site may bill for an E-consult with the appropriate Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) code when the benefits or services delivered meet the procedural definition and components of the national CPT/HCPCS code as defined by the American Medical Association (AMA) or any other extended guideline described in the Medi-Cal provider manual.

C. Consent for Telehealth Services
1. Prior to the delivery of health care services via synchronous telehealth, the healthcare provider at the originating site must verbally inform the patient that telehealth may be used and obtain written or verbal consent from the patient for this use.
   a. The verbal consent must be documented in the patient's medical record.
   b. Providers are required to share additional information with Partnership Members such as:
      1) Right to in-person services
      2) Voluntary nature of consent
      3) Availability of transportation to access in-person services
      4) Limitations/risks of receiving services via telehealth
      5) Availability of translation services
2. Synchronous telehealth services can be provided to Partnership members by any Partnership credentialed healthcare provider with the Member's written or verbal consent, as documented in the patient's medical record.

D. Confidentiality
1. All federal and state laws regarding the confidentiality of health care information and a patient's rights to his or her medical information apply to telehealth services.

E. New Patient Relationships
a. All Providers may establish new patient relationships via synchronous video Telehealth visits.
b. All Providers may establish new patient relationships via audio-only synchronous interaction only if one or more of the following criteria applies:
   1) Healthcare services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, and intimate partner violence.
   2) The patient requests audio-only modality.
   3) The patient attests they do not have access to video.

F. Credentialing of Providers Who Provide Telehealth Services to Partnership Members in a Hospital Setting
1. Licensed healthcare providers providing telehealth services to hospitalized Partnership Members from outside the hospital setting must be Medi-Cal certified providers in the State of California and qualified providers credentialed through Partnership or through an organization with delegated authority for credentialing, as approved by the Partnership Credentials Committee.
2. The governing body of the hospital whose patients are receiving telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant site hospital or telehealth entity, as described in Sections 482.12, 482.22 and 485.616 of Title 42 of the Code of Federal Regulations.

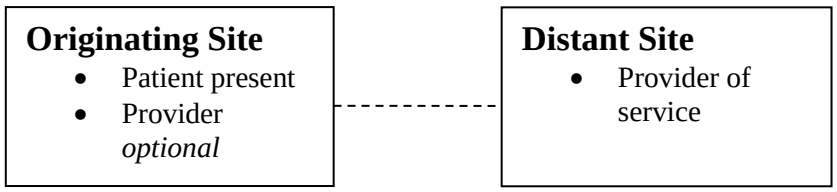
G. Required Equipment
1. The audio-video telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the CPT/HCPCS code for the benefits or services being delivered through

telehealth. The telecommunication equipment must be of a quality to adequately complete all necessary components to document the level of service for the CPT/HCPCS code billed.

H. Reimbursement for Telehealth Services

Unless otherwise agreed to by Partnership and provider, Partnership will reimburse providers at the same rate whether a covered service is provided in-person or through Telehealth, when the service is the same regardless of the modality of delivery, as determined by the Provider's description of the service on the claim. (Applies to both video and audio-only visits as medically appropriate. The reimbursement terms for each of the three models are summarized below:

1. Reimbursement for Traditional Synchronous Telehealth Services



a. If a licensed provider is also present at the telehealth Originating Site with the patient and a progress note is generated by the originating provider, the visit is reimbursable.
   1) The scope of the interaction with the originating provider should be documented in the progress notes that is distinct from those provided by the Distant Site and will be the basis of the Evaluation and Management (E&M) and other CPT/HCPCS code(s) billed.
   2) If an E&M code is included, the transmission cost fees may be billed. No modifier is needed at the Originating Site.

b. Health care providers (with the exception of Federally Qualified Health Centers [FQHCs], Rural Health Centers [RHCs] and Tribal Health Centers as noted below) are required to document Place of Service Codes on claims, which indicate that services were provided or received through a telecommunications system. A place of service (POS) code is a two-digit code that indicates the location where a medical service was provided. The Centers for Medicare & Medicaid Services (CMS) maintains the POS code set, which is used by healthcare providers and insurance companies to determine the correct payment amount for a service
   1) Place of Service Code 02 indicates that telehealth services were provided to a patient in a location other than their home.
   2) Place of Service Code 10 indicates that the patient was in their home while receiving telehealth services.
   3) The Place of Service Code requirement is not applicable for FQHCs, RHCs or Tribal Health Centers as noted in the Originating Site table below.

c. Each telehealth provider must be licensed in the State of California (if a licensure pathway is available), enrolled as a Medi-Cal Provider or Non-Physician Medical Practitioner, and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and be located in California or a border community.

d. Partnership covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:
   1) The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment

2) The services delivered via telehealth meet the procedural definition and components in the CPT-4 or HCPCS code(s) associated with the covered service; and
3) The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

e. Certain types of services *cannot* be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service.

f. An FQHC/ RHC/ Tribal Health Center may choose to sub-contract with a specialist and pay them directly. Under these circumstances, the FQHC/ RHC/ Tribal Health Center would bill for the originating site and the specialty service on two separate claims.
1) Designated telehealth specialist providers Referral Authorization Form (RAF) requirements vary, see policy MCUP3124 Referral to Specialists (RAF) Policy.
2) The Partnership system would need to be set up for the specific specialty, and if not, the Network Services Department should be contacted.

Billing guidelines for Originating Site Providers (Traditional Synchronous Telehealth Services):

Originating Site (Traditional Synchronous Telehealth Services)	
Service	**Code(s)**
Site facility fee	Q3014 (once per day, per patient, same provider)
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient, per day, same provider)*
Licensed provider fee (*if present*)	E&M codes 99201 – 99205; 99211 – 99215, T1015 (for health centers) and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.

***** FQHCs/ RHCs/ Tribal Health Centers cannot bill for site fee or transmission charges. These charges are included in their FQHC/RHC Prospective Payment System (PPS) rate or the IHS Memorandum of Agreement (MOA) rate.

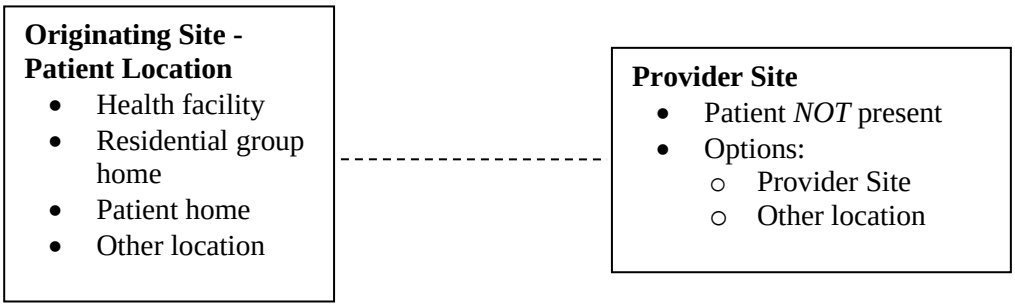
Billing guidelines for Distant Site Providers (Traditional Synchronous Telehealth Services):

Distant Site (Traditional Synchronous Telehealth Services)	
Service	**Code(s)**
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient, per day, same provider)
Initial hospital care or subsequent hospital care, critical care (new or established patient)	Inpatient hospital: 99221 – 99233 Critical care: 99291 or G0508; 99292 or G0509
Extended Inpatient Care	99418
Consultations: Office or other outpatient (initial or follow-up) Inpatient, and confirmatory	99242 – 99245; 99252 - 99255
Genetic Counseling	S0265

Nutrition Counseling per Partnership Guidelines (See Policy MCUP3052)	97802, 97803, 97804, G0108, G0109
ACE Screenings	G9919, G9920
Mental Health Assessment (by Non-Physician)	H0031 (may be billed up to 1 hour, once per year)
Perinatal Educational Counseling (by Partnership approved Perinatal Services Providers/Practices)	Z6400-Z6414 Z6500 Z6200-Z6208 Z6300-Z6308
Other Covered Procedures that can be provided by telemedicine	All CPT/HCPCS codes are potentially allowed if they meet requirements as described in section VI.H.1.d. of this policy.
Procedures that are Excluded from Telehealth:	**<u>These Codes are Excluded:</u>** **Anesthesia:** 00100 - 01999 and 99100 - 99157 **Surgery:** 10021 - 69990 **Speech/Occupational/Physical Therapy:** 96101 to 97546, 97750 - 97799, 97161 - 97164, and 98970 - 98972vie **Wound care:** 97597 - 97610; **Acupuncture, osteopathic manipulation, chiropractic manipulation**: 97810 - 98943 **Refer to section VI.H.1.e. of this policy for other codes that may be excluded.**
Virtual/Telephonic Communications (Brief video or phone visit with a patient or a provider in office and patient remote from office [in lieu of office visit])	**G2012 -** Brief virtual/telephonic communication with another practitioner or with a patient (5-10 minutes of medical discussion. **Place of Service Code "02"** - must be documented on the claim to indicate that services were provided through a telecommunications system in a location other than the patient's home. **Place of Service Code "10"** - must be documented on the claim to indicate that services were provided through a telecommunications system while the patient was in their home.
Required Modifier - video	95 modifier required for all CPT-Codes except Transmission T1014 Cost code and G2012 code.
Required Modifier – audio-only	93 modifier required for all CPT-Codes except Transmission T1014 Cost code and G2012 codes.**

** Effective January 1, 2024, all Providers furnishing applicable Covered Services via audio-only synchronous interactions must also offer those same services via video synchronous interactions to preserve Member choice.

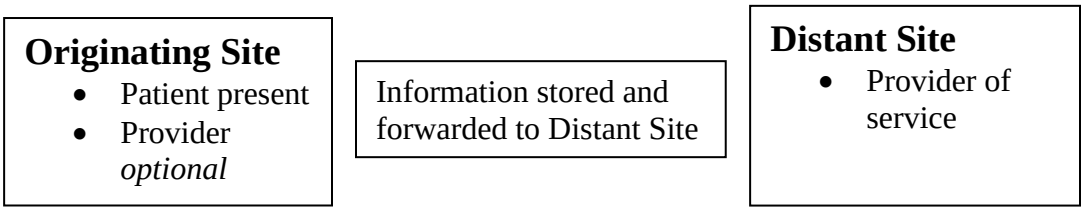
2. Reimbursement for Synchronous: Provider to Patient Telehealth Services



Billing Guidelines for the Provider Site (Synchronous: Provider to Patient Telehealth Services):

Provider Site	
Service	**Code(s)**
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient, per day, same provider)
Licensed provider fee (*if present*)	E&M codes 99201 – 99205; 99211 – 99215, T1015 and other non-excluded codes.
Nutrition Counseling (per policy MCUP3052 Medical Nutrition Services)	97802, 97803, 97804, 99539
Required Modifier	95 modifier required for all CPT-Codes except Transmission Cost codes

3. Reimbursement for Asynchronous Telehealth Services (Store and Forward and E-Consult)



a. Asynchronous telehealth visits are reimbursable if a licensed provider is also present at the telehealth Originating Site, with the patient present, and a progress note is generated by the originating provider.
b. The scope of the interaction with the originating provider should be documented in the progress note, and will be the basis of the CPT code(s) used. If a CPT code is included, the originating site fee and the transmission cost fees may still be billed. No modifier is needed.
c. Health care providers (with the exception of FQHCs, RHCs, and Tribal Health Centers as noted below) are required to document Place of Service Codes on the claim, which indicate that services were provided or received through a telecommunications system. A place of service (POS) code is a two-digit code that indicates the location where a medical service was provided. The Centers for Medicare & Medicaid Services (CMS) maintains the POS code set, which is

used by healthcare providers and insurance companies to determine the correct payment amount for a service.

1) Place of Service Code 02 indicates that telehealth services were provided to a patient in a location other than their home.
2) Place of Service Code 10 indicates that the patient was in their home while receiving telehealth services.
3) The Place of Service Code requirement is not applicable for FQHCs, RHCs or Tribal Health Centers as per "c." below.

d. Originating site and transmission fee restrictions and billing rules are not applicable for FQHCs, RHCs or Tribal Health Centers. Services provided through telehealth are subject to the same program restrictions, limitations and coverage that exist when the service is provided in-person. For policy information specific to FQHCs, RHCs, or Tribal Health Centers, please see the Medi-Cal provider manual.

Billing guidelines for Originating Site Providers (Asynchronous Telehealth Services):

Originating Site (Asynchronous Telehealth Services)	
Service	**Code(s)**
Site facility fee	Q3014
Licensed provider fee (*if present*)	E&M codes 99201 – 92205; 99211- 99215; T1015, and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider, not on the excluded list

e. Special Billing Guidelines for Asynchronous Retinal Photography - Originating Site Providers: If a provider uses asynchronous telehealth for eye exam screenings through the use of a retinal camera located at the originating site, special billing guidelines apply when the originating site is paying the specialist directly for reading the results of the retinal photographs. A licensed provider does not need to be present for retinal photography service to be reimbursable. If no provider is present at visit, bill using the following CPT codes:

Originating Store and Forward Site (Retinal Photography)	
Service	**Code**
Retinal photography with interpretation for services provided by optometrists or ophthalmologists	92250 (Do not use modifier)
OR	
Remote imaging for detection of retinal disease with analysis and report under physician supervision, unilateral or bilateral	92227 (Do not use modifier)
Site facility fee	Q3014

1) If provider is present at visit, E&M codes can also be billed as noted in the chart above for

"Originating Site (Asynchronous Telehealth Services)." The scope of the interaction with the originating provider should be documented in the progress note. The originating site fee and the transmission cost fees may still be billed. No modifier is needed.

Billing Guidelines for Distant Store and Forward Site Providers (Asynchronous Telehealth Services):

Distant Store and Forward Site	
Service	**Code(s)**
Office consultation, new or established patient Follow up hospital visit	99242 – 99243 99231 – 99233
Remote evaluation of recorded video and/or images submitted by the patient.	**G2010 –** Remote evaluation of recorded video and/or images submitted by an established patient including interpretation, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an E&M service or procedure
Retinal photography with interpretation for services provided by optometrists or ophthalmologists (should not be used if originating site is submitting claims with this code).	92250
Required Modifier:	All asynchronous, store-and-forward services are billed with a "GQ" modifier

f. Special Billing Guidelines for Asynchronous E-Consult service - Distant Site Providers:
   1) In order to bill for E-Consults, the health care provider at the distant site (consultative provider) must create and maintain the following:
      a) A record of the review and analysis of the transmitted medical information with written documentation of date of service and time spent (between 5 - 30 minutes) and
      b) A written report of case findings and recommendations with conveyance to the originating site
   2) The health care provider at the distant site (consultant) who meets Medi-Cal standards may bill for E-Consult services provided using the following CPT code in conjunction with modifier "GQ":

Distant Store and Forward Site (E-Consult)	
Service	**Code**
E-Consult, electronic consultation	99451
Required Modifier:	"GQ" modifier

   3) In some cases, the originating site may bill for Store and Forward (E-Consults) if at least 16 minutes are required to complete the E-Consult.

Originating Store and Forward Site (E-Consult)	
Service	**Code**

E-Consult, electronic consultation	99452
Required Modifier:	"GQ" modifier

I. Exclusions
1. Partnership does not cover communication between providers outside that described in this policy as E-Consult.
2. Partnership does not cover patient - provider communication via email, text, or written communication.
3. Video communication of poor resolution and phone communication are only covered if they meet the criteria stated in section VI.F. and in the chart labeled "Billing Guidelines for Distant Site Providers (Traditional Synchronous Telehealth Services)" in section VI.H.1.

VII. REFERENCES:

A. Medi-Cal Provider Manual: Medicine: Telehealth *(medne tele)*; Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) *(rural)*; Tribal Federally Qualified Health Centers *(tribal fqhc)*; Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics *(ind health)*
B. Title 42 of the Code of Federal Regulations Sections 482.12, 482.22 and 485.616
C. Welfare and Institutions Codes (WIC) § 14132.725
D. Department of Health Services (DHCS) All Plan Letter (APL) 23-007 Telehealth Services Policy (4/10/2023)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

3/14/12, 2/18/15; 01/20/16; 04/20/16; 09/21/16; 9/20/17; *10/10/18; 08/14/19; 02/12/20; 01/13/21; 01/12/22; 01/11/23; 11/08/23; 02/12/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits

covered under Partnership.

Partnership authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

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2024 Patient Experience CG-CAHPS Evaluation

Prepared by:
Amber Newell

January - 2025

MY2024 Patient Experience

Measure Overview

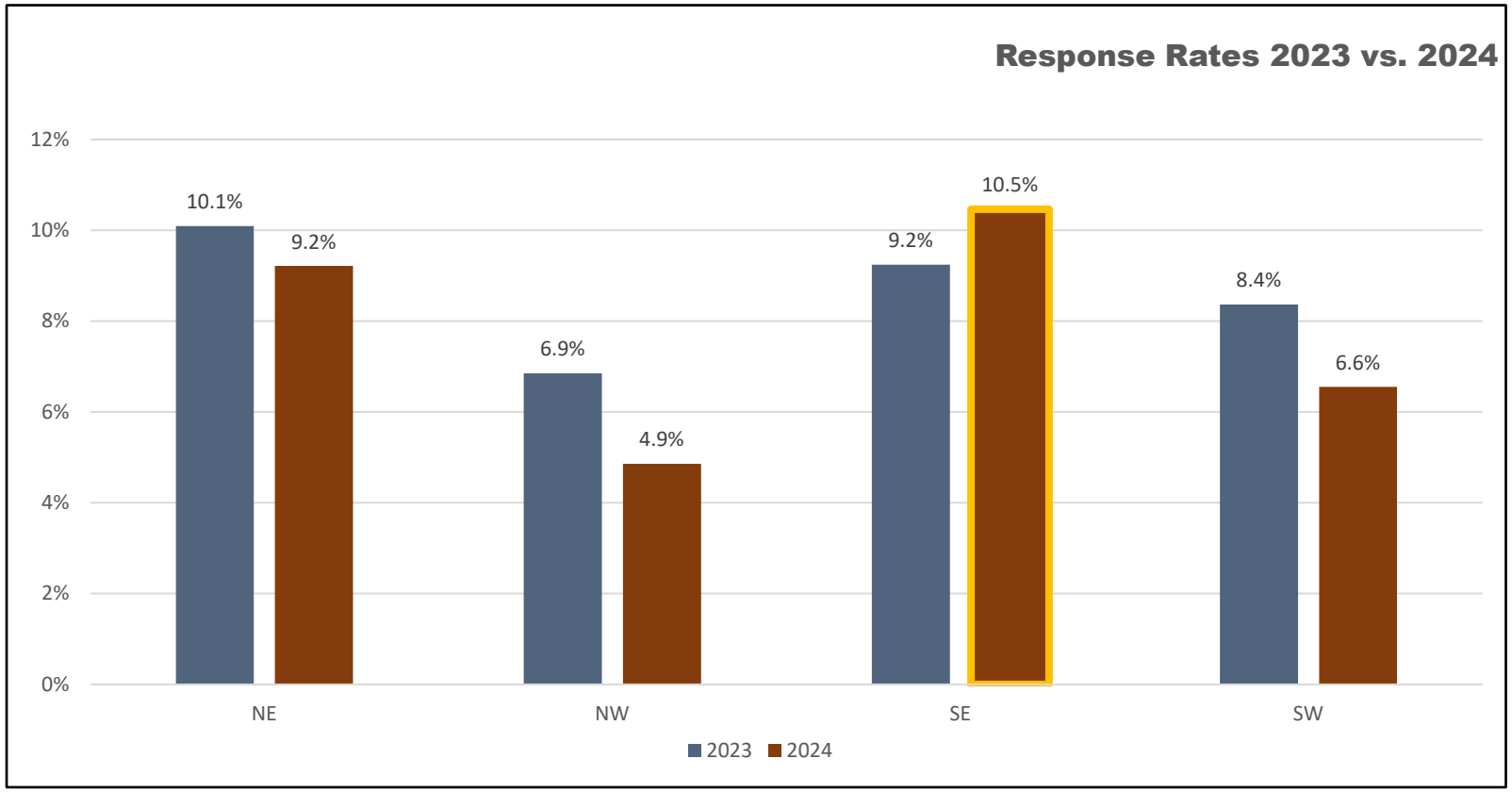
- ✓ Clinician & Group (**CG**) Consumer Assessment of Healthcare Providers and System (**CAHPS**)
- ✓ **Purpose**: Provides information on the member's experience with healthcare providers and gives a general indication of how well a practice meets patient expectations. Results summarize patient experience with care through an overall rating question, composites, and question summary rates.
- ✓ **How to qualify**: Sufficient patient volume is defined as having at least one visit by 2400 unique PHC members between April 1, 2023 and March 31, 2024
- ✓ **Fielding Timeframe**: Between May and July of the 2024 measurement year
- ✓ **Eligible patients**: Adult (18 and older), Child (younger than 18) as of the last day of the measurement period and had a visit with a practice clinician during the measurement period (scheduled or walk-in)
- ✓ **Total Sampled**: 2400 patients sampled from each Parent Organization
- ✓ **Surveys**: Adult and Child (English), Adult and Child (Spanish)
- ✓ **Composite Measures**: Measures with combined results from closely related survey questions into a single measure to summarize performance; **Four composite measures**: ***Access, Communication, Coordination of Care, and Office Staff***
- ✓ **Scores**: Group score and Site score. Both scoring types are a combination of results from closely related survey questions. The Group score for the Parent Organization is used to score the Patient Experience measure and create targets for the next measurement year. Scores range from zero (0) to one (1)

MY2024 Patient Experience

Response Rate and Targets

- 2024 25th % Access Target: 34.83%
- 2024 50th % Access Target: 41.97%

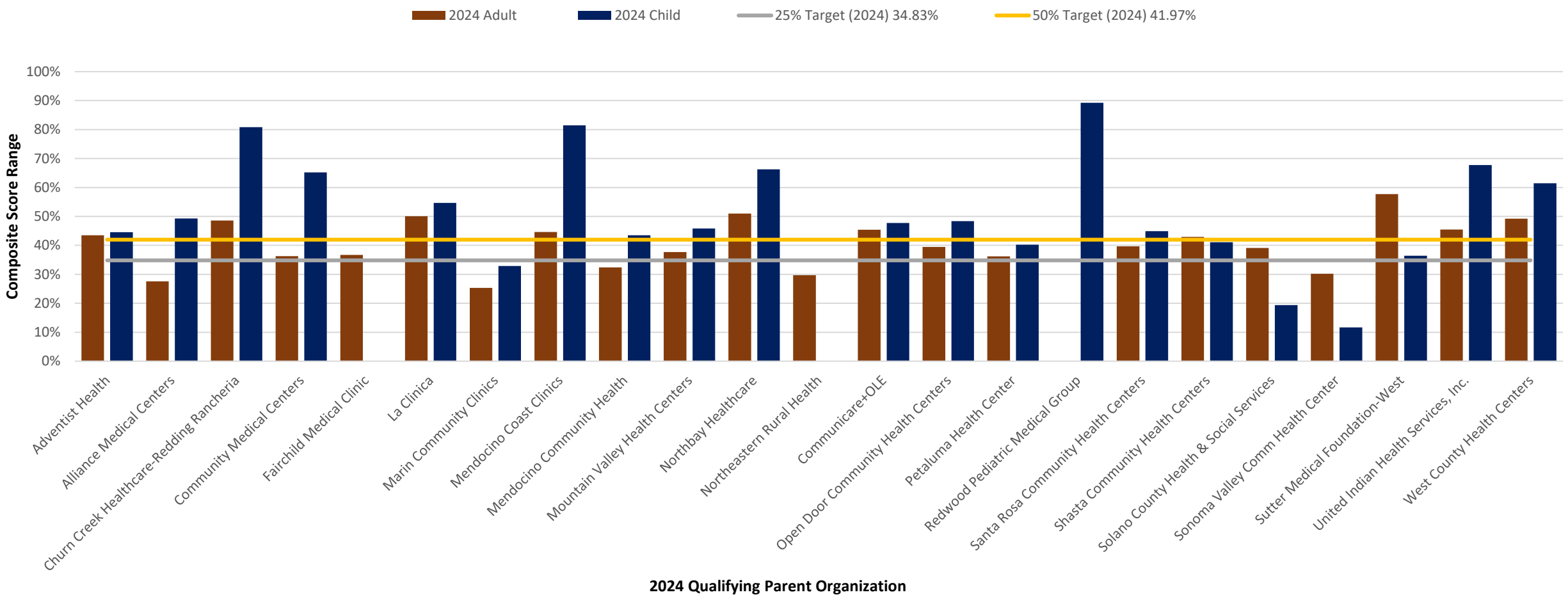
- 2024 25th % Communication Target: 65.12%
- 2024 50th % Communication Target: 70.31%



MY2024 Patient Experience

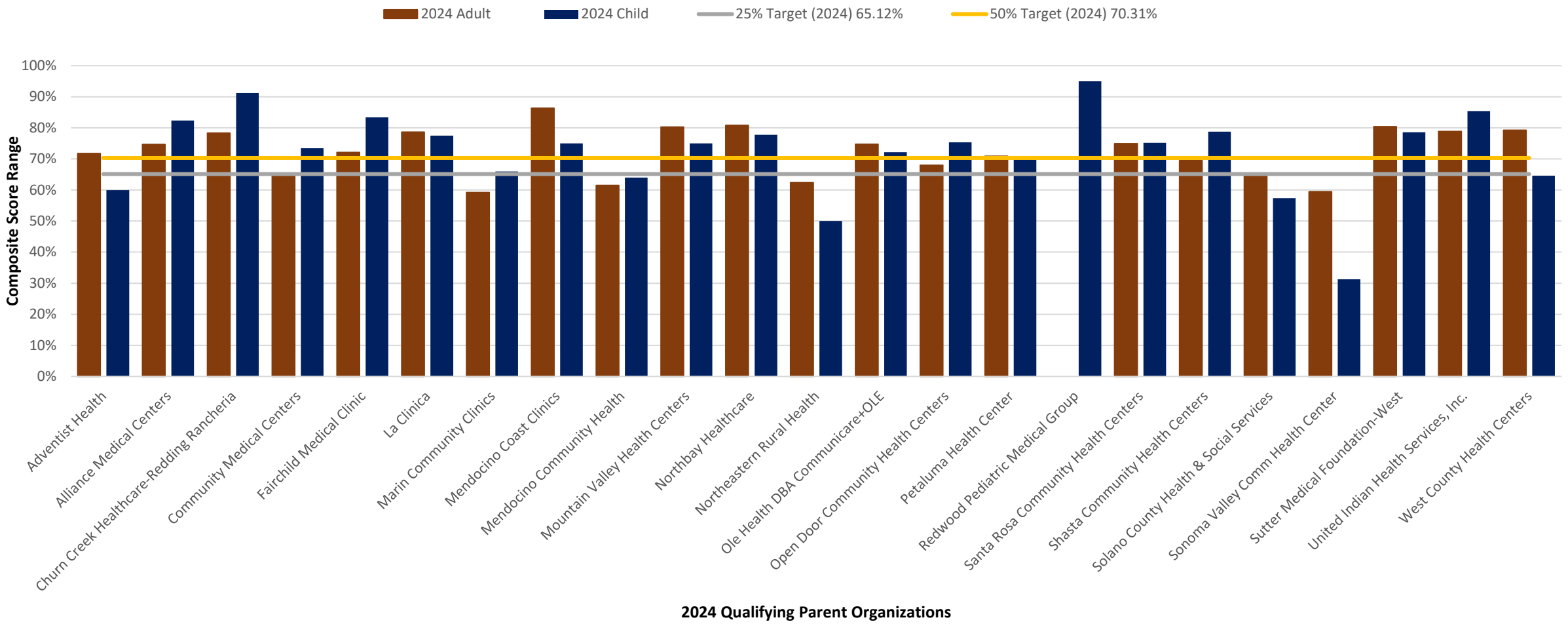
Access

2024 Group Access Scores by Parent Organization

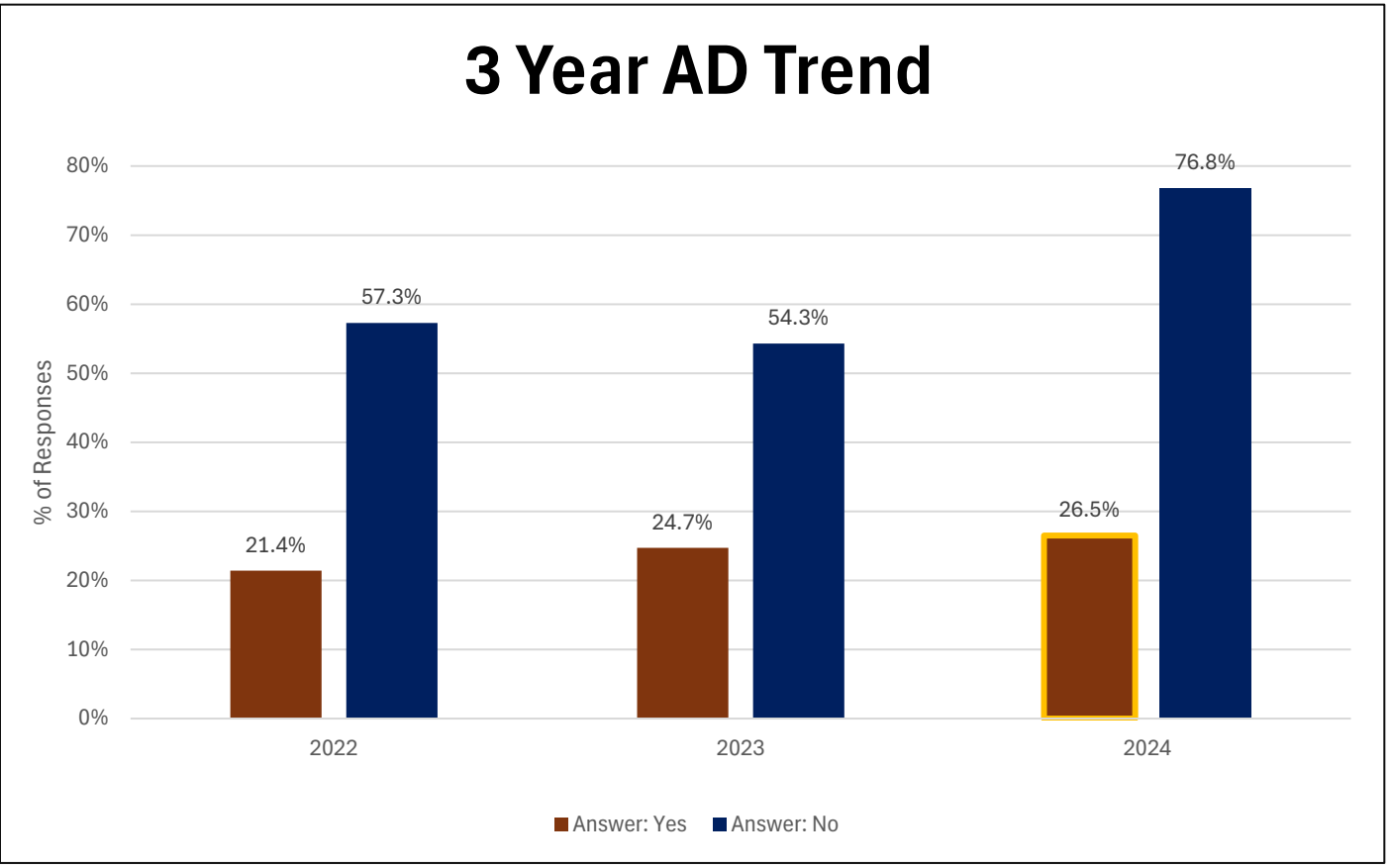


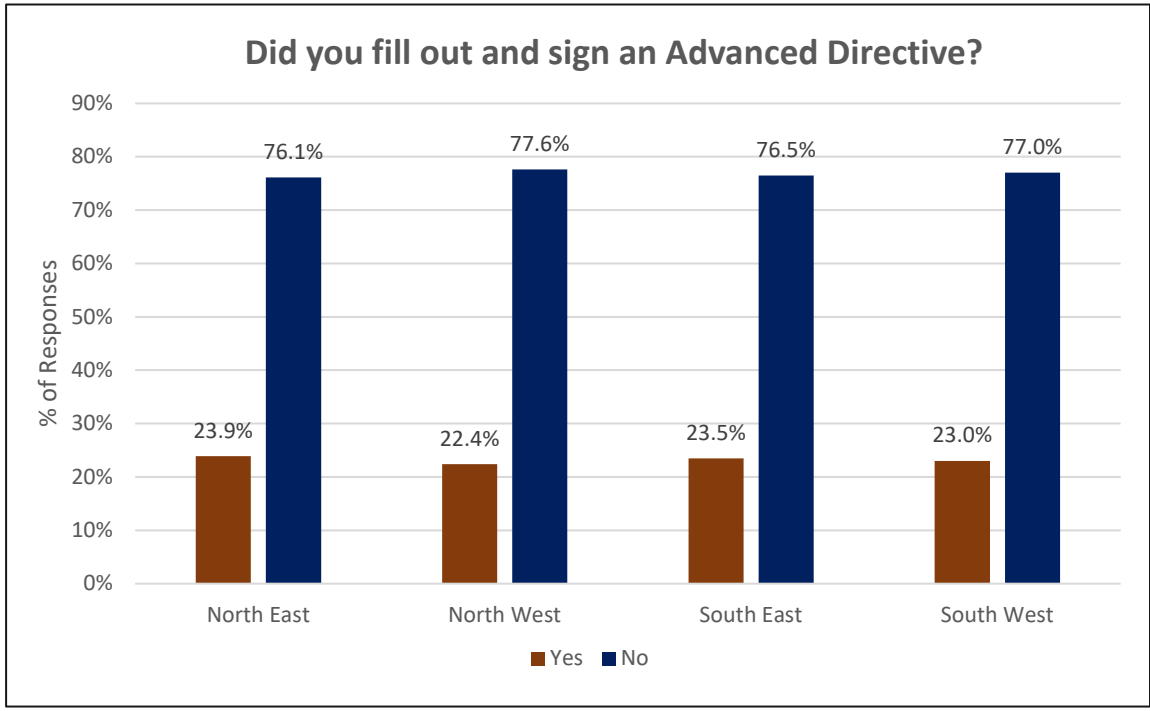
MY2024 Patient Experience
Communication

2024 Group Communication Scores by Parent Organization

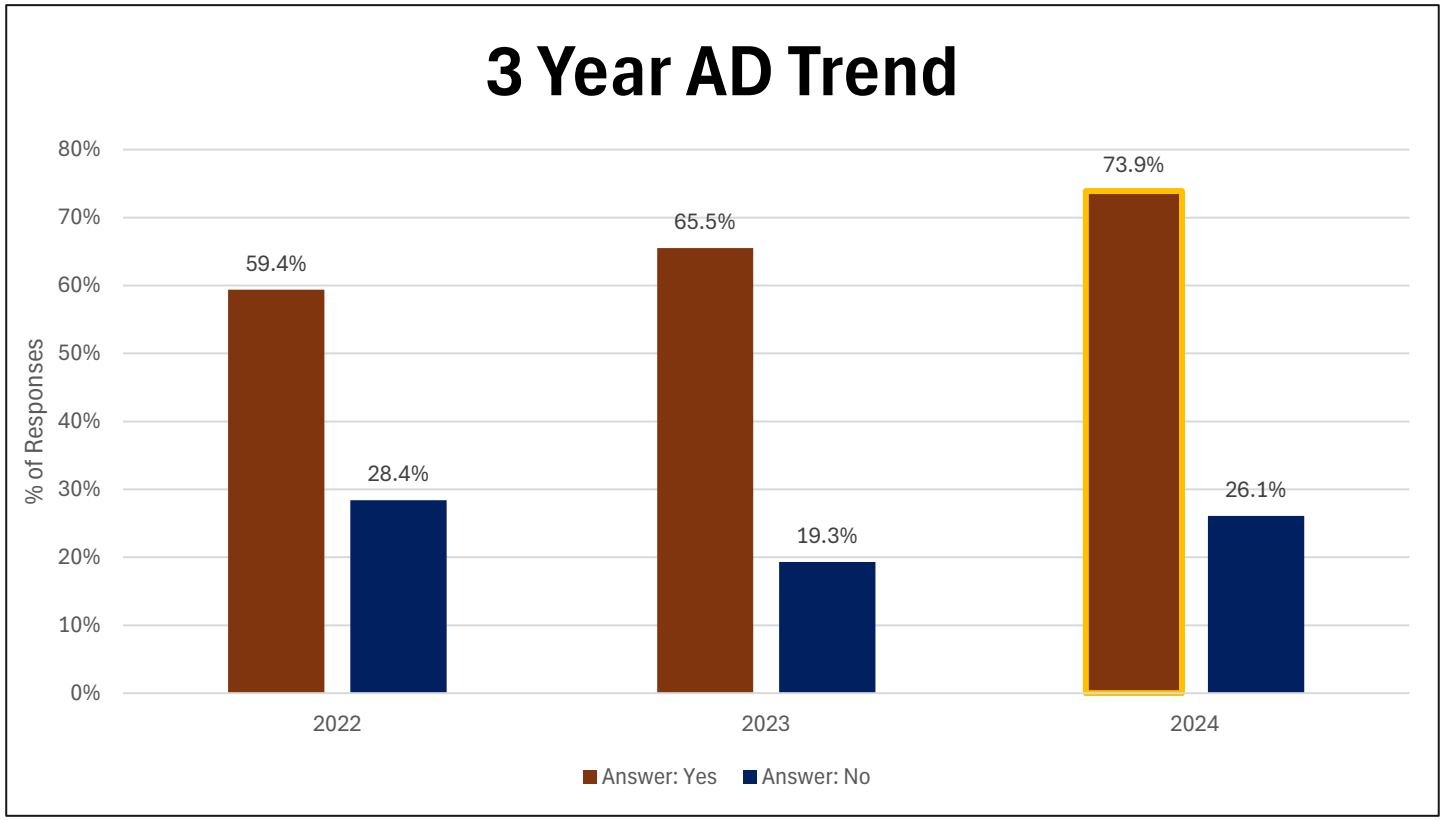


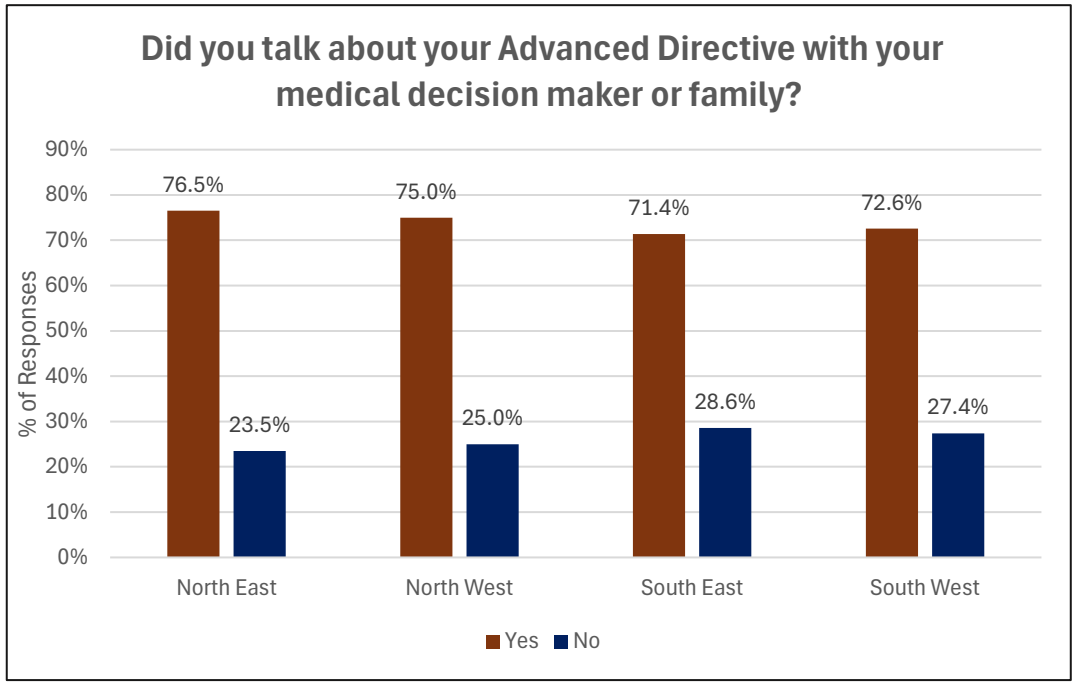
MY2024 Pt Exp: Advanced Directive
Question #1



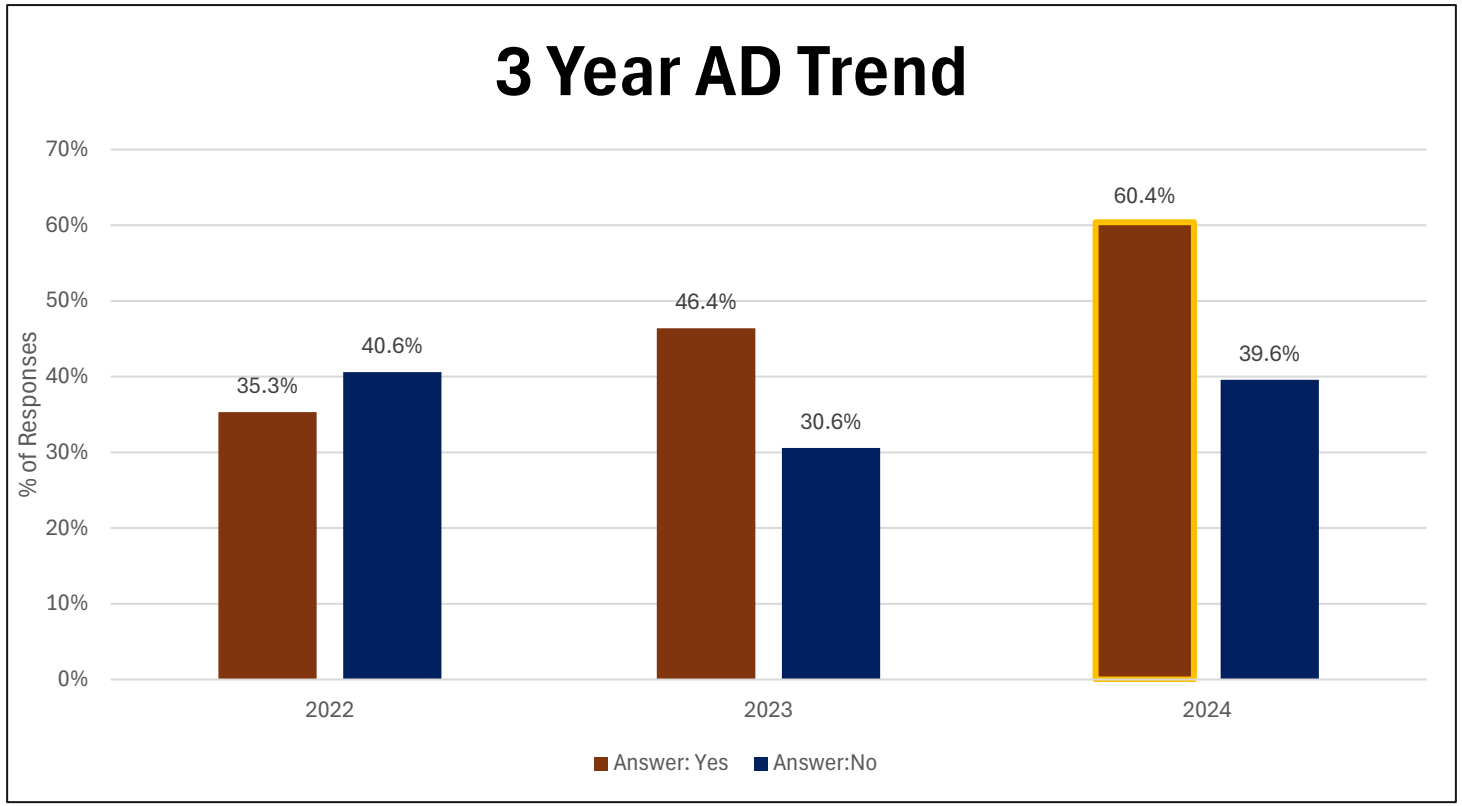


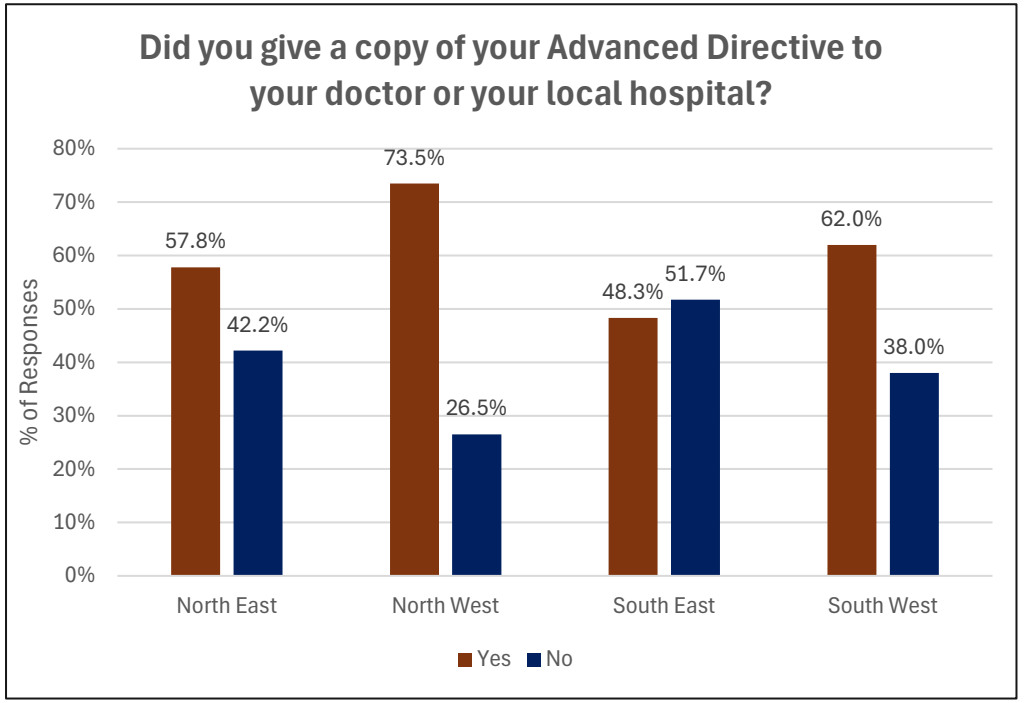
MY2024 Pt Exp: Advanced Directive
Question #2





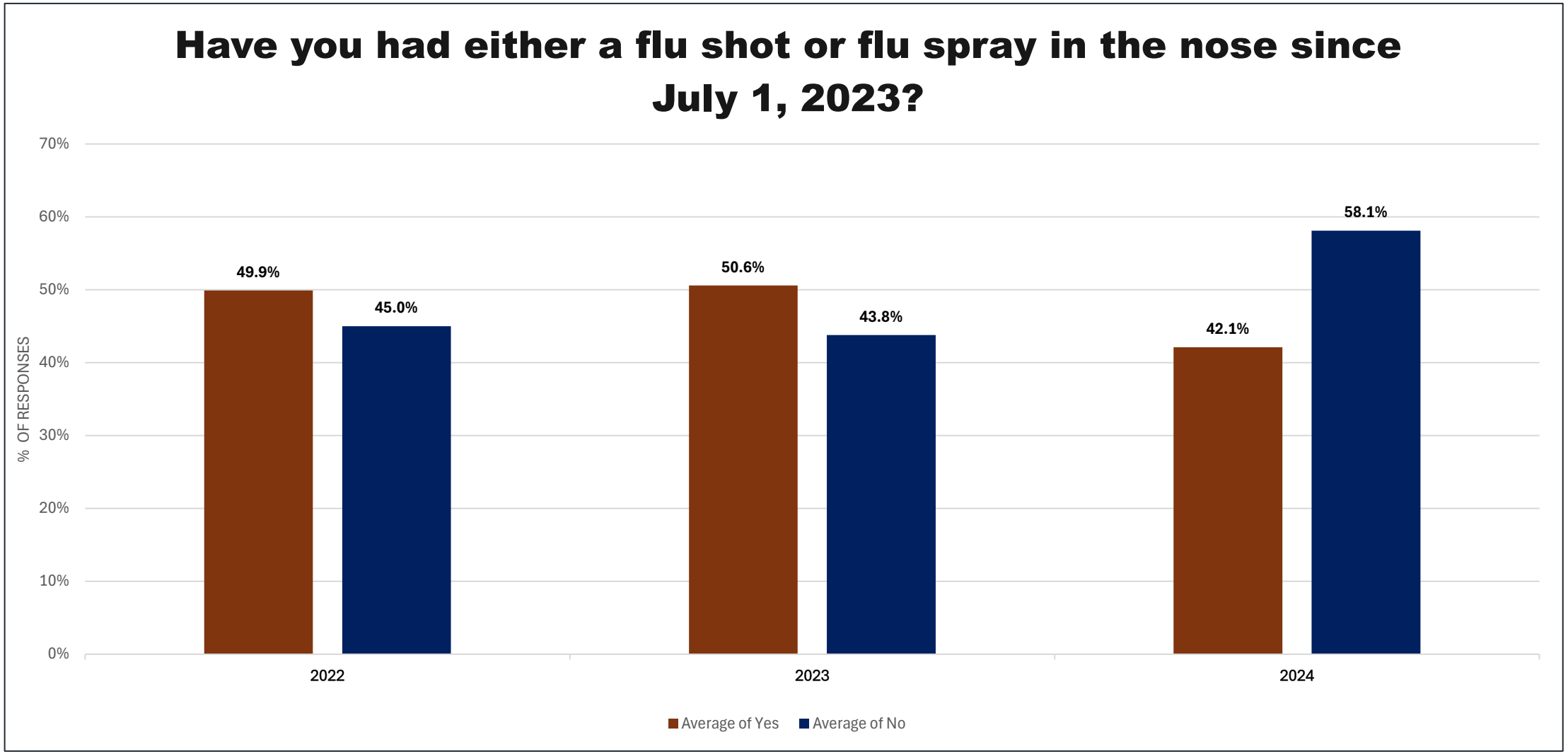
MY2024 Pt Exp: Advanced Directive
Question #3





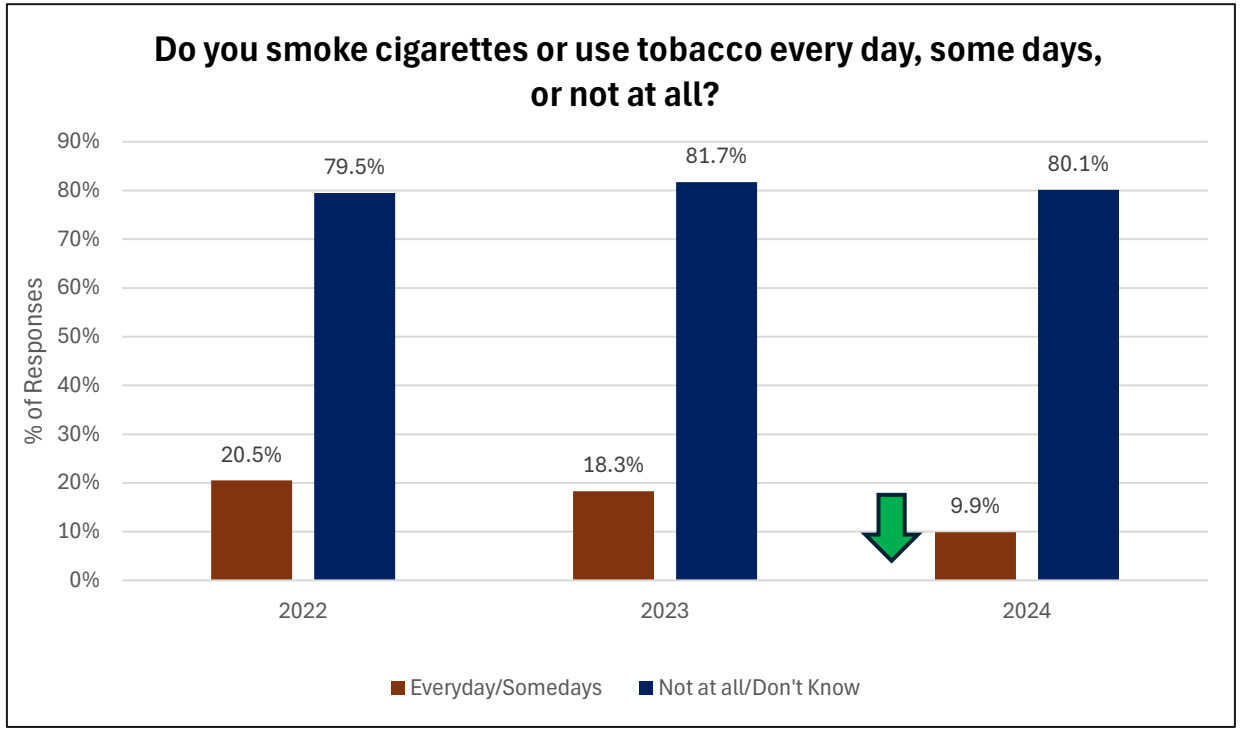
MY2024 Patient Experience

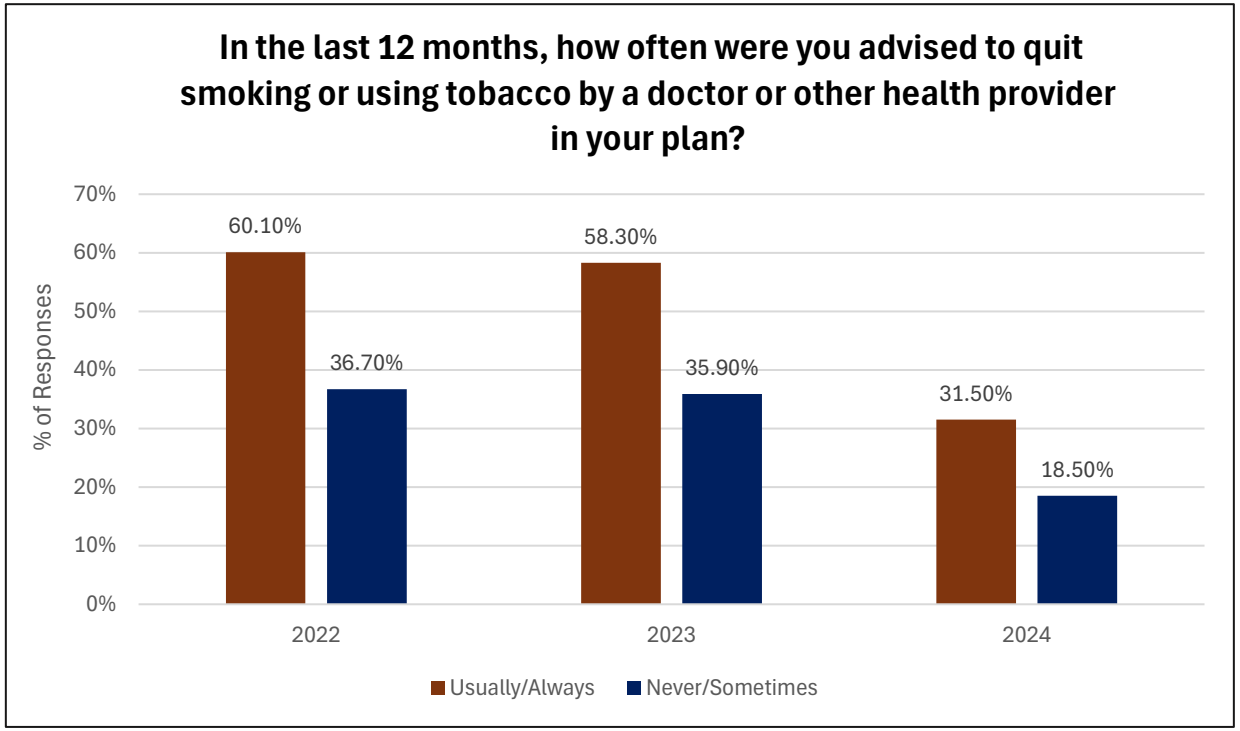
Flu - 3 Year Trend



MY2024 Patient Experience

Tobacco Use

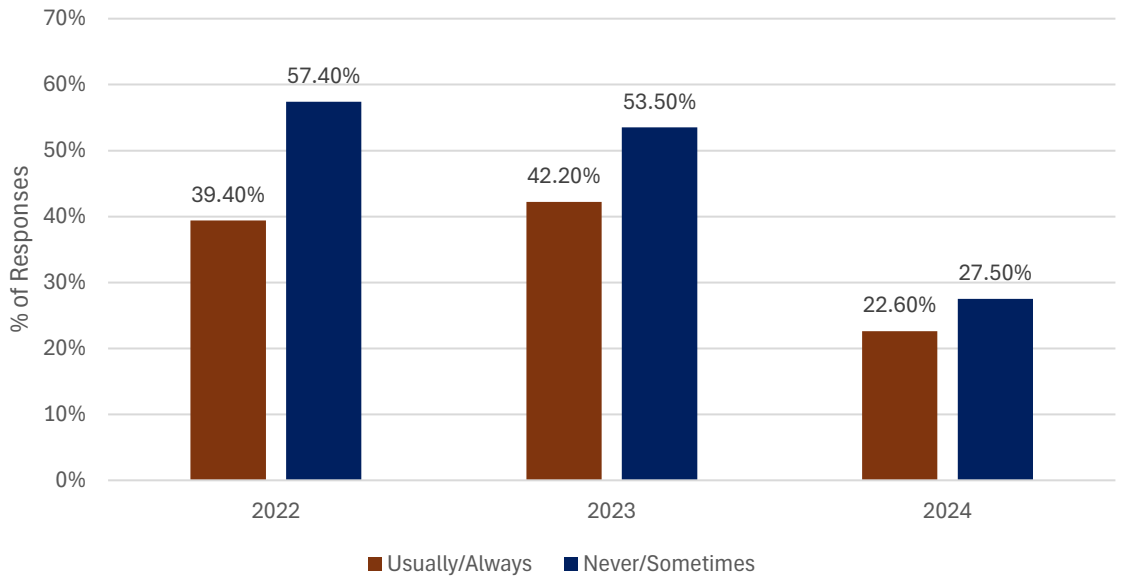




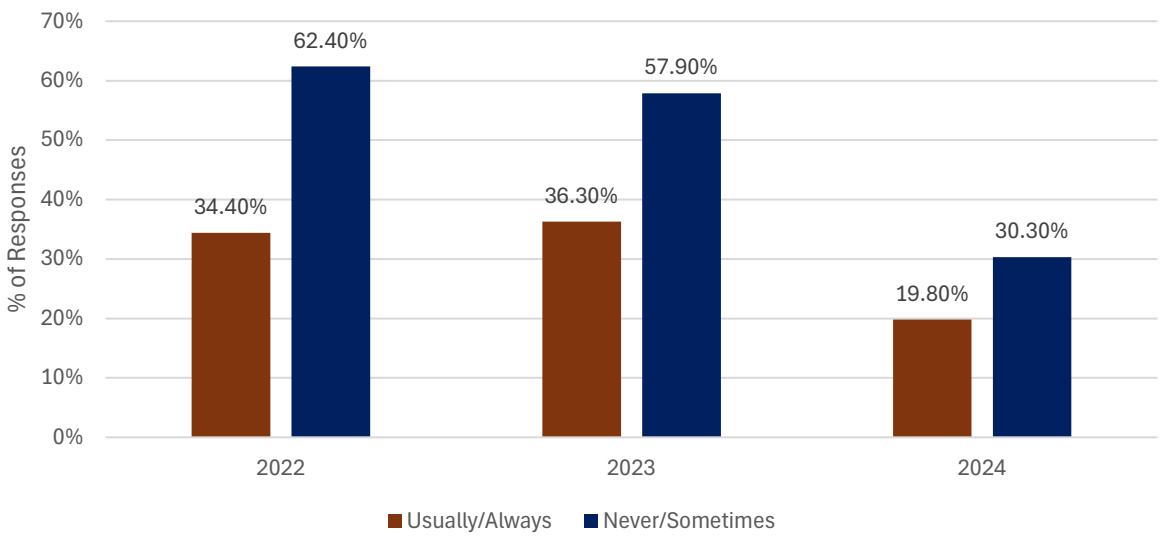
MY2024 Patient Experience

Tobacco Use

In the last 12 months. How often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco?



In the last 12 months, how often did you doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco?



MY2024 Patient Experience
Summary

- **23** qualifying Parent Organizations (POs)

- **Access**: **20** POs had at least one survey type, Adult or Child, at the 25th and **16** at the 50th
  - *Churn Creek Healthcare-Redding Rancheria, Mendocino Coast Clinics and Redwood Pediatric* top three

- **Communication**: **19** POs had at least one survey type, Adult or Child, at the 25th and **18** at the 50th
  - *Churn Creek Healthcare-Redding Rancheria, United Indian Healthcare and Redwood Pediatric* top three

- **Advanced Directive:** All 3 questions show upward trend of average YES responses
- **Flu:** Average YES response remains hovered at 50% for 2022 & 2023 with a decrease in YES response for 2024
- **Tobacco Use:** Q1 largest drop in Everyday/Somedays responses

- **Response Rates**: South East region had the largest increase in response rates
- **What's coming?:** Press Ganey will continue to be our vendor for the 2025 CG CAHPS

- **MY2024 Targets**:

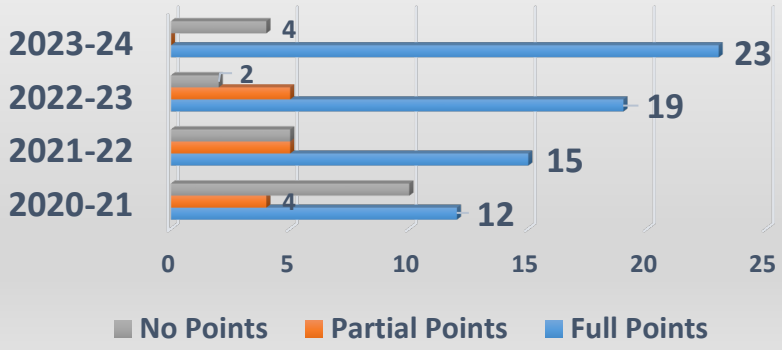
(Full points) 50th Percentile	**Access 41.97%**	**Communications 70.31%**
(Partial Points) 25th Percentile	**Access 34.83%**	**Communications 65.12%**

2023-24 Partnership Hospital QIP Evaluation Summary

The Hospital Quality Improvement Program (Hospital QIP) offers substantial financial incentives to participating hospitals that meet performance targets for selected quality and operational efficiency measures. This evaluation is an analysis of performance from July 1, 2023, through June 30, 2024.

33 Hospitals Participating
Average QIP Score of 79%
15 Hospitals Recognized for ≥ 90%
8 Hospitals earned 100%
$7 Million Distributed

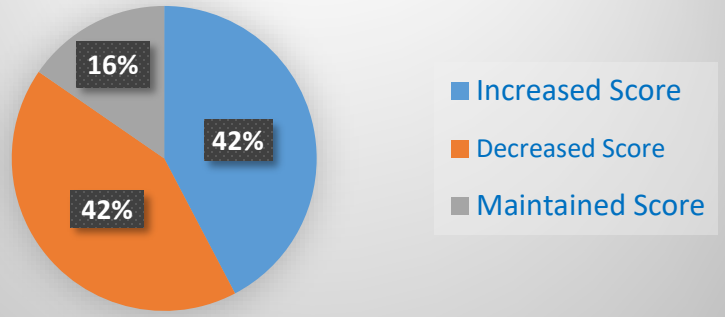
Risk Adjusted Readmissions Improvement 2020 Through 2024



HQIP Efforts to Improve Care:

- 32 out of 33 hospitals attended Partnership's 2024 Hospital Quality Symposium which focused on Health Equity, Reducing Readmissions, treating members with Mental Health and Substance Use Disorders, and utilizing CalAIM to effectively deliver care to underserved populations.
- Increased communication with providers through mid-year check-ins and operations meetings.
- 6 Expansion County Hospitals joined the HQIP in January 2024
- Collaborated internally and externally to include three new measures in 2024-25 specifications targeting expanding delivery privileges, increase screening mammography capacity and increasing 7-day clinical follow-up after discharge.

HQIP Scores MY 2022-23 Compared to 2023-24



Notable incremental Performance Improvements:

- 15 hospitals recognized as Top Performers with a score of ≥ 90%
- This includes the whole Providence System of Hospitals!
- 12% increase in hospitals earning full points for RAR this year over last year!
- More members have been seen for Medication Assisted Treatment than previous years
- CAIR utilization continued to increase this year to the point that the measure has been retired for MY 2024-25.
- All Cal Hospital Compare Patient Experience Scores improved
- 3 out of 4 Maternity Measures had an improvement over last year

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2023-24 Hospital Quality Incentive Program Evaluation

Troy Foster

Program Manager II

January 2025

HQIP Historic Highlights

2020/2021 — 26 Hospitals Participating

- $7M Performance-Based Incentive Payments Distributed
- Largest Hospitals (100+ beds) Participating in VBAC & Palliative Care PCQC Data Submission
- Health Equity Introduced
- 5 Top Performing Hospitals (≥ 90% Score

2021/2022 — 26 Hospitals Continue

- $8.1M Performance-Based Incentive Payments Distributed
- 12 Top Performing Hospitals (≥ 90% Score)

2022/2023 — 26 Hospitals Continue

- $10.9M Performance-Based Incentive Payments Distributed
- 12 Top Performing Hospitals (≥ 90% Score)
- 6 Hospitals scored 100%

2023/2024 — 33 Hospitals Participating

- $7 M Performance-Based Incentive Payments Distributed
- 15 Top Performing Hospitals (≥ 90% Score)
- 8 Hospitals scored 100%

33 Hospitals in 24 Counties

Maternity Hospitals indicated by *

Expansion County Hospitals shown in green

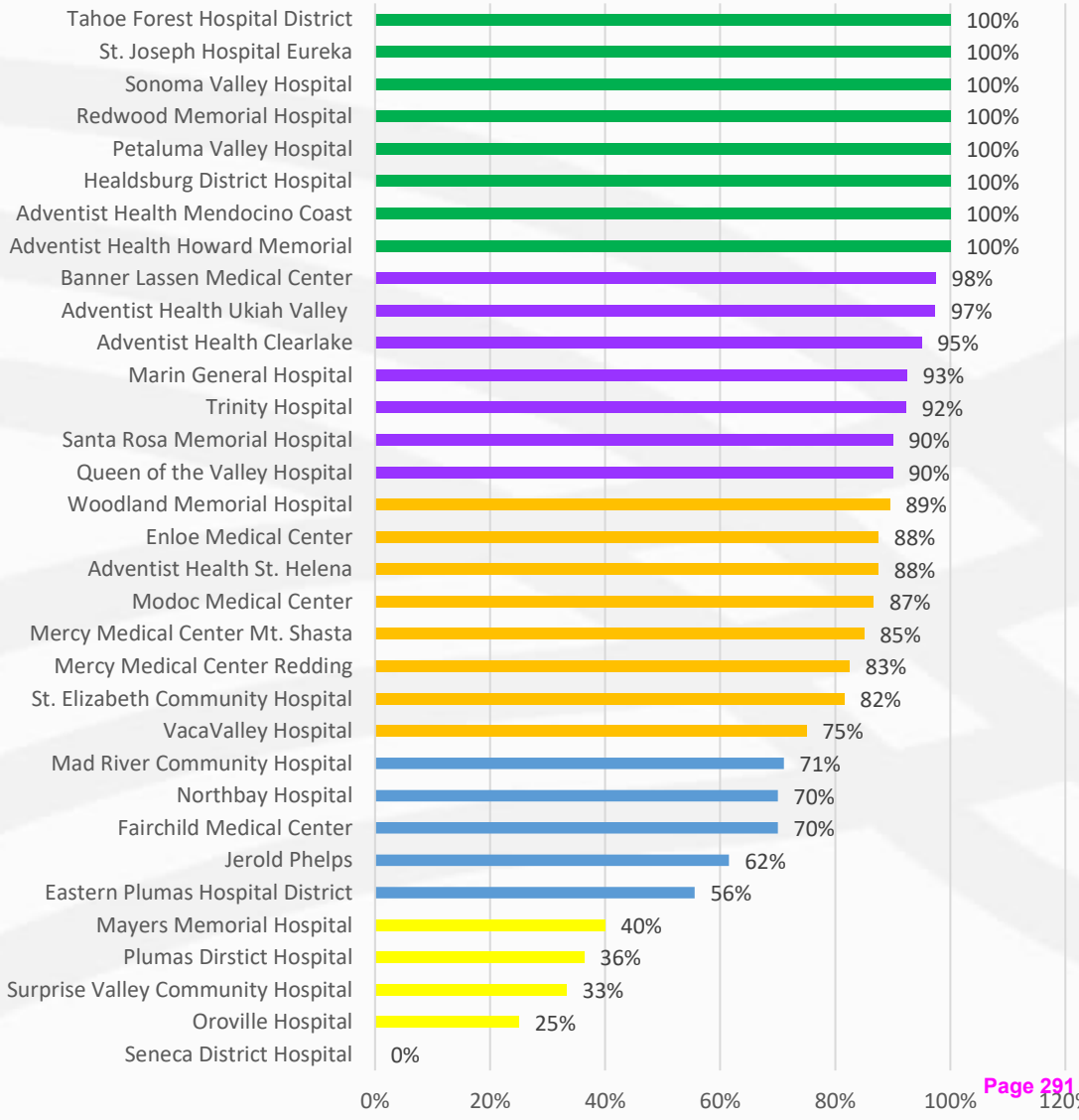
Hospital	Size
Adventist Health Clearlake*	Small
Adventist Health Howard Memorial	Small
Adventist Health Mendocino Coast	X-Large
Adventist Health St. Helena	Large
Adventist Health Ukiah Valley*	Small
Banner Lassen Medical Center*	Small
Eastern Plumas District Hospital	Very Small
Enloe Medical Center*	X-Large
Fairchild Medical Center*	Small
Jerold Phelps Community Hospital	Very Small
Mad River Community Hospital*	Large
MarinHealth Medical Center*	X-Large
Mayers Memorial Hospital	Very Small
Mercy Medical Center Mt. Shasta*	Small
Mercy Medical Center Redding*	X-Large
Modoc Medical Center	Very Small
NorthBay Hospital*	X-Large

Hospital	Size
Oroville Hospital	X-Large
Plumas District Hospital	Very Small
Healdsburg Hospital	Small
Petaluma Valley Hospital	Large
Providence Queen of the Valley Hospital*	X-Large
Providence Redwood Memorial Hospital	Small
Providence Santa Rosa Memorial*	X-Large
Providence St. Joseph Hospital Eureka*	X-Large
Seneca District Hospital	Very Small
Sonoma Valley Hospital	Small
St. Elizabeth Community Hospital*	Large
Surprise Valley	Very Small
Tahoe Forest Hospital District	Small
Trinity Hospital	Very Small
VacaValley Hospital	Large
Woodland Memorial Hospital*	Large

Measurement Year 2023-2024

Hospital QIP Performance Highlights

2023-2024 Final Scores & Highlights



8 Hospitals earned a 100% HQIP Score!
This includes 1 Expansion County Hospital.

15 Top Performers earning ≥ 90%

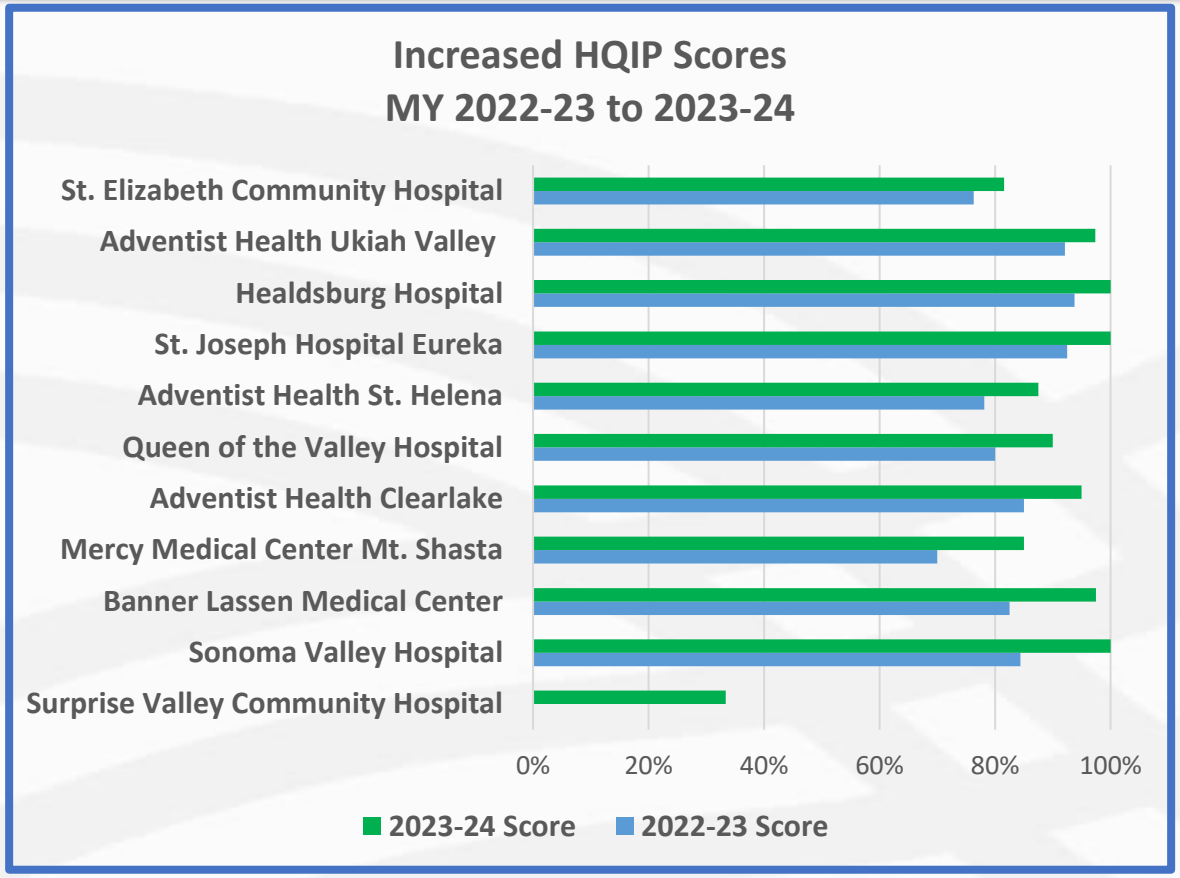
The Entire Providence System earned Top Performer Status!

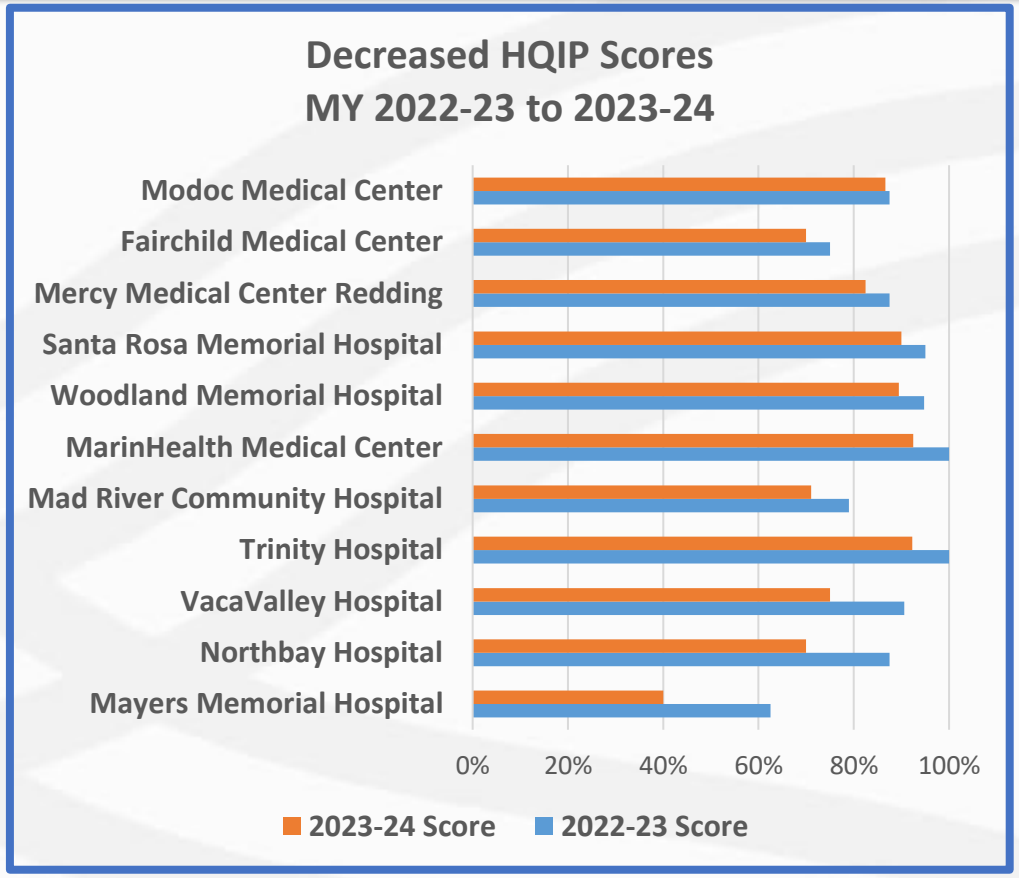
22 out of 33 hospitals earned > 75%!

4 Hospitals maintained 100% from MY 2022-23

Hospitals that improved scores, raised them by an average of 12 percentage points

Increase & Decrease Breakdown

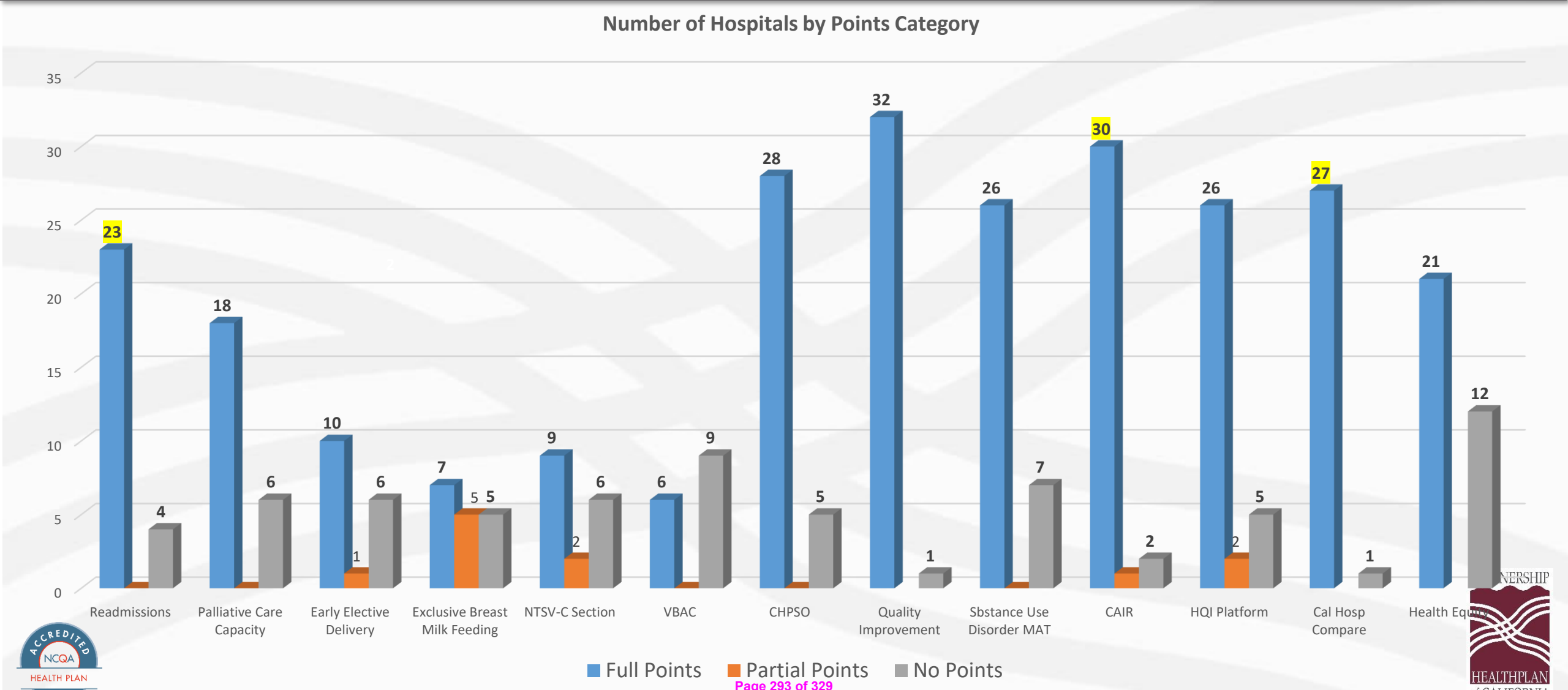




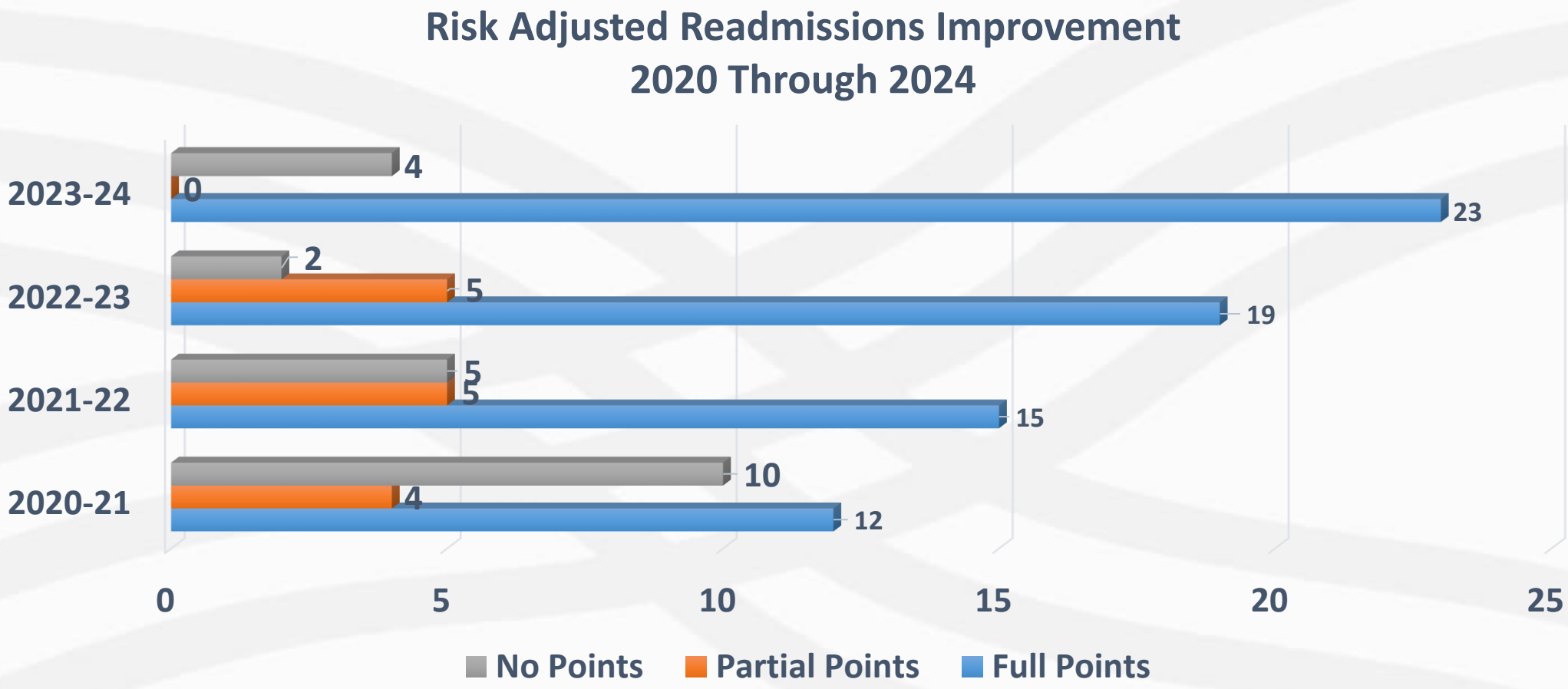
4 Hospitals with No Change in Score		
Hospital	**22-23 Score**	**23-24 Score**
Howard Memorial	100%	100%
Mendocino Coast District Hospital	100%	100%
Redwood Memorial	100%	100%
Petaluma	100%	100%

2023-24 Performance Relative to Targets

Point Distribution by Measure



Risk Adjusted Readmission Trends



Note: The six new Expansion County Hospitals were not held accountable to the RAR Measure in 2023-24 so the count of hospitals is only 27 instead of 33

Maternity Measure Breakdown

Vaginal Birth After C-Section (VBAC):
Full Points Target is ≥ 5%
Hospitals performed very well with an
Average rate of **19.2%** in MY 2023-24
6 out of 8 hospitals earned **Full Points,**
2 hospitals earned **Zero Points**
(one did not sign up with CMQCC).
Represents a 5% decrease from 2022-23 MY.

Early Elective Delivery (EED) before 39 Weeks:
Full Points Target is ≤ 1.0%
Performance over the past two measurement years
has been essentially the same with:
58% of the hospitals earning **Full Points**,
1 hospital earning **Partial Points**, and
6 hospitals earning **Zero Points**
Represents an 8% increase from last year

Exclusive Breast Milk Feeding (EBMF):
Full Points Target is ≥ 75%
Average score is right at **71%** so no changes needed.
7 out of 17 hospitals earned **Full Points,**
5 out of 17 hospitals earned **Partial Points,**
5 out of 17 hospitals earned **Zero Points,**
7 hospitals **improved** percentage, while **7 decreased**.

Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean:
Full Points Target is < 21%
The average score is **.6%** higher than last year.
4 out of 14 hospitals had **positive change**
7 out of 14 hospitals had **negative change**

Program Evaluation Summary

Hospital Quality Improvement Program: Efforts in Improving Care

- 32 out of 33 hospitals attended Partnership's 2024 Hospital Quality Symposium focusing on Health Equity, Reducing Readmissions, addressing Mental Health struggles & CalAIM transformation to compassionate and effectively treat the underserved.
- Increased communication with providers through mid-year check-ins
- 6 Expansion County Hospitals joined the HQIP in January 2024
- Collaborated internally and externally to include three new measures in 2024-25 specifications targeting expanding delivery privileges, increase screening mammography capacity and increasing 7-day clinical follow-up after discharge.

2023-24 How Does the Hospital QIP Results Reflect Improved Care?

Notable incremental performance improvements:

- 15 hospitals recognized as Top Performers with a QIP score of ≥ 90%
- The whole Providence System of Hospitals earned Top Performer Status!
- Hospitals earning full points for RAR this year increased 12% over last year!
- More members have been seen for Medication Assisted Treatment
- CAIR utilization continued to increase this year to the point that the measure has been retired.
- All Hospitals improved Cal Hospital Compare Patient Experience Scores
- Community partnerships were enhanced

Program Evaluation Summary

Recommendations for 2024-25

- Continue fostering of participant engagement
- Increase support - preliminary RAR reports & 7-day follow-up reports
- Encourage hospital to use the Hospital Quality Institute Platform to analyze their data to improve quality
- Utilize community partnerships
- Continued systemic focus on Health Equity
- Encourage hospital participation Vaccinations For Children program to increase immunizations.

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Evaluation of Cervical Cancer Self-Swab Testing Pilot

Internal Quality Improvement (IQI) and
Quality/Utilization Advisory Committee (Q/UAC)
January 2025

About Us

Mission:

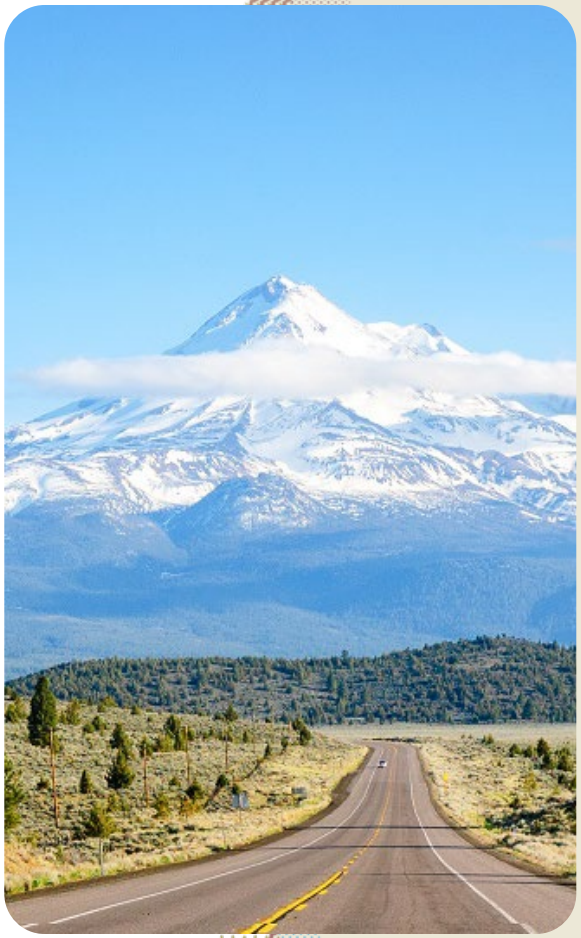
To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

Agenda

Background
Planning
Implementation
Lessons Learned
Next Steps



CONTEXT

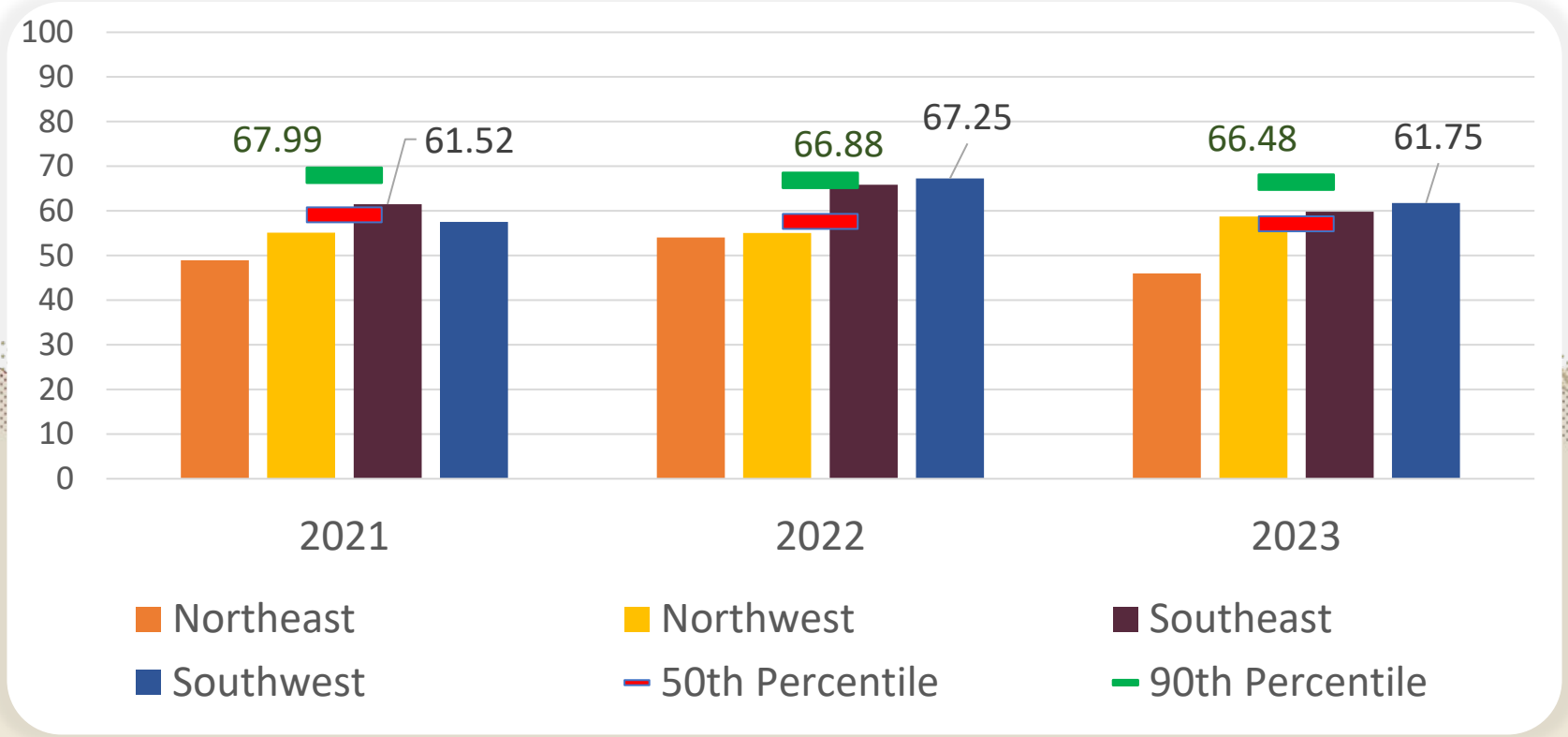
International Research suggests that self swab sample collection method is an acceptable method for cervical cancer screening.

At home HPV tests were already available for patients to order independently.

Anticipated FDA Approval

Research also shows that self collected samples will increase uptake of cervical cancer screening.

Cervical Cancer Screening Performance



Pilot Objectives

Acquire intelligence on successful implementation of a self- swab option in the primary care office

Develop educational materials for Members

Planning

Recruited 5 Providers in 4 regions

Criteria for patient inclusion in pilot:

Current Partnership member

At least 30 years old

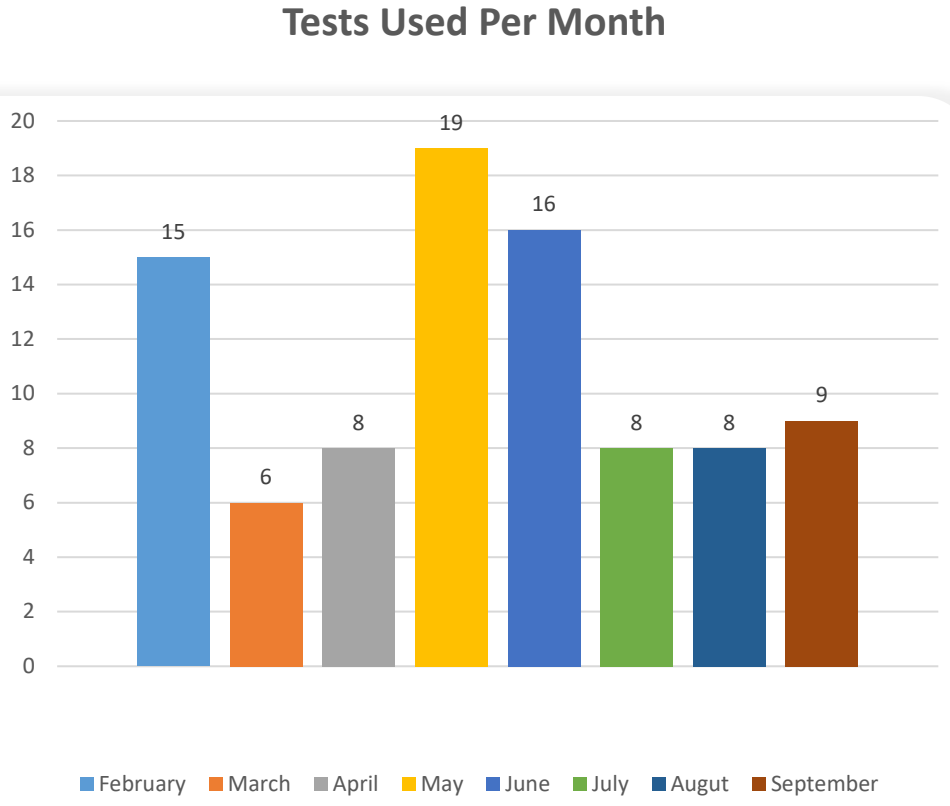
Have declined a CCS through traditional method

200 Test Kits

Complete by May 31, 2024

Implementation

- First Tests used February 5, 2024.
- Three large Practices used 89 test kits.
- Pilot was called to a close September 2024.

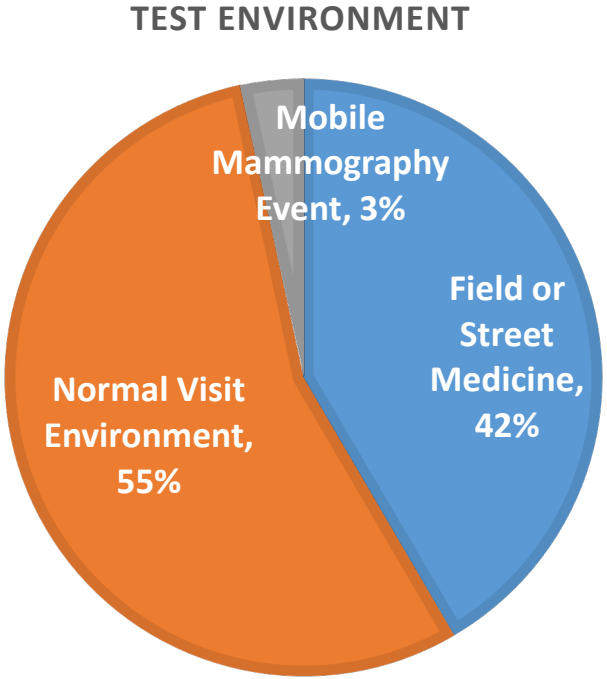


Implementation

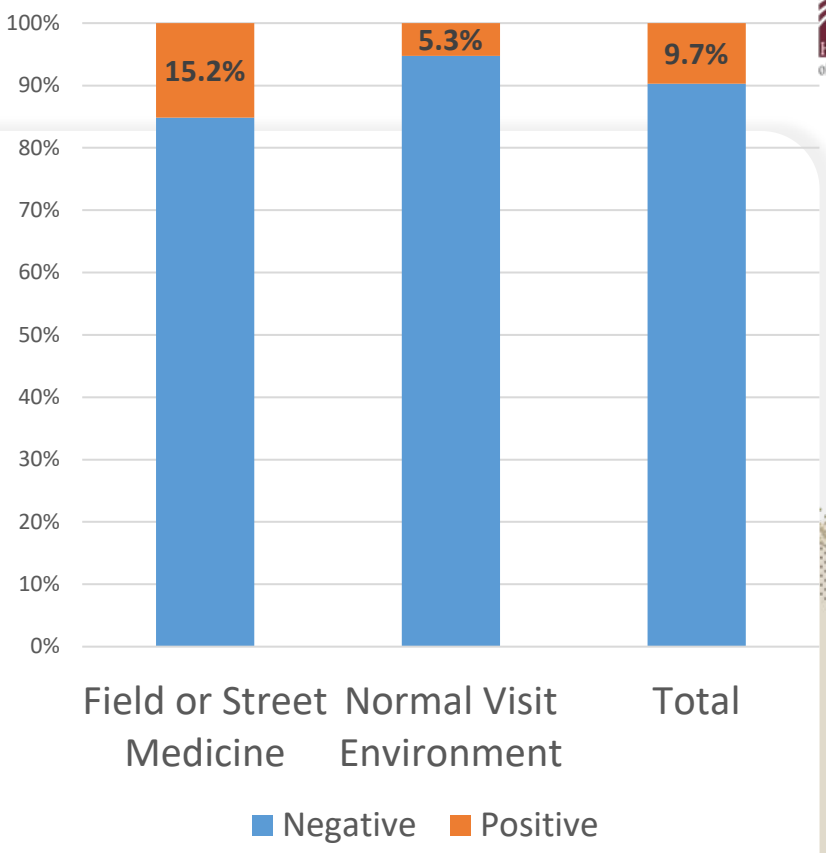
2 of 3 practices started in their field / mobile medicine environment.

1 of these expanded to brick-and-mortar practice after slow start.

1 did a mini-test of integrating self swab option at their mobile mammography events.



Test Results by Collection Environment



Lessons Learned

- Patients are ready for this option.
- Small pilot show individuals who do not otherwise have access to screening can access screening and understand their risk for cervical cancer.
- Providers are ready for this option for their patients.
- Provider concern: If patients aren't willing to do a pelvic exam for screening, will they be willing to do a colposcopy if the test is positive?
- Not the end all be all: Some patients still aren't interested in the screening, even if the sample can be self collected. "What if it's positive, what then?" – Street medicine patient.

Next Steps

Evolving Landscape

NIH NATIONAL CANCER INSTITUTE

About Cancer | Cancer Types | Research | Grants & Training | News & Events | About NCI

Home › News & Events › Cancer Currents Blog › FDA Approves HPV Tests That Allow for Self-Collection in a Health Care Setting

FDA Approves HPV Tests That Allow for Self-Collection in a Health Care Setting

Subscribe

July 24, 2024, by Sharon Reynolds

On May 14, the Food and Drug Administration (FDA) expanded the approvals of two tests that detect cancer-causing types of human papillomavirus (HPV) in the cervix. Both tests are used as part of screening for cervical cancer.

Under these expanded approvals, people can now be offered the option to collect a vaginal sample themselves for HPV testing if they cannot have or do not want a pelvic exam. However, the collection, which involves a swab or brush, must be done in a health care setting, such as primary care offices, urgent care, pharmacies, and mobile clinics.

The tests included in the approvals are Onclarity HPV, made by Becton, Dickinson and Company (BD), and cobas HPV, made by Roche Molecular Systems.

For now, the option to self-collect a vaginal sample for HPV testing must be done in a health care setting.
Credit: iStock/SDI Productions

FDA Approved self swab in the healthcare setting.

Awaiting Lab Vendors to operationalize this option.

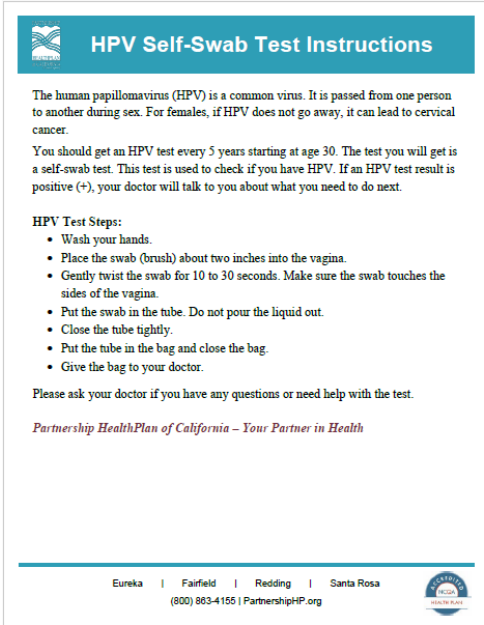
Evolving Landscape

Work with laboratory providers (LabCorp and Quest) to ensure that they are providing self swab testing supplies to our providers.

Advocate for access to new FDA approved self swab materials and testing to be available through contracted laboratory providers.

Provide support to the network to promote this new option to patients in clinic.

Educate providers on integrating the self swab option into workflows. Develop patient and provider education.



HPV Self-Swab Test Instructions

The human papillomavirus (HPV) is a common virus. It is passed from one person to another during sex. For females, if HPV does not go away, it can lead to cervical cancer.

You should get an HPV test every 5 years starting at age 30. The test you will get is a self-swab test. This test is used to check if you have HPV. If an HPV test result is positive (+), your doctor will talk to you about what you need to do next.

HPV Test Steps:

- Wash your hands.
- Place the swab (brush) about two inches into the vagina.
- Gently twist the swab for 10 to 30 seconds. Make sure the swab touches the sides of the vagina.
- Put the swab in the tube. Do not pour the liquid out.
- Close the tube tightly.
- Put the tube in the bag and close the bag.
- Give the bag to your doctor.

Please ask your doctor if you have any questions or need help with the test.

Partnership HealthPlan of California – Your Partner in Health

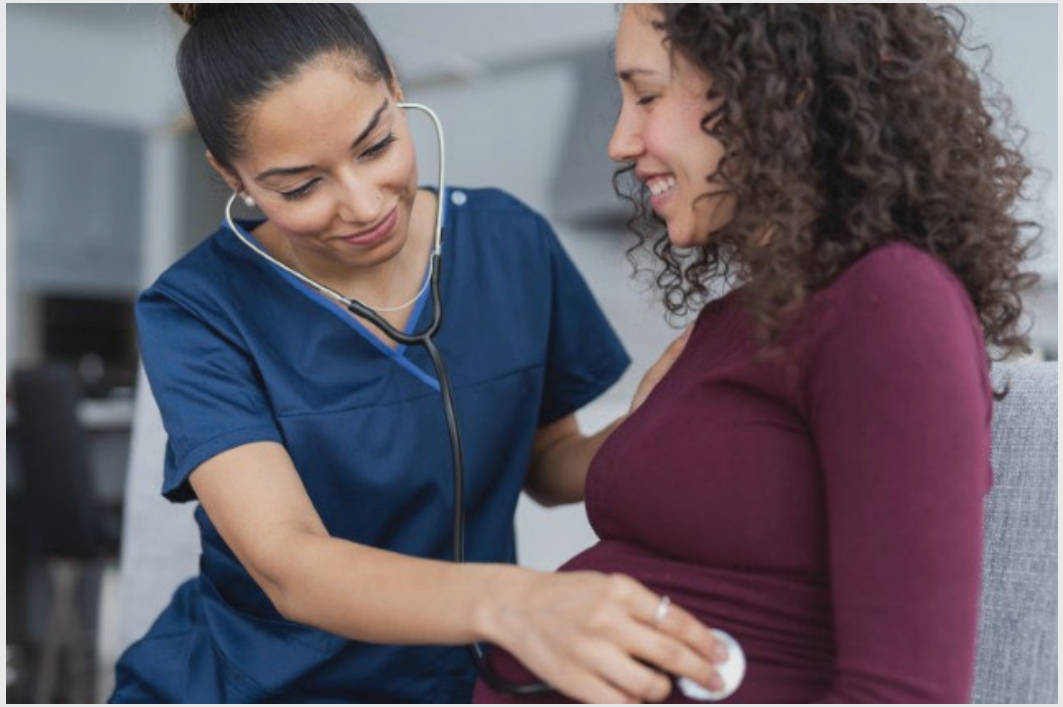
Eureka | Fairfield | Redding | Santa Rosa
(800) 863-4155 | PartnershipHP.org

Perinatal Quality Incentive Program (PQIP)

2023-2024 Evaluation

Amy McCune,
Manager of Quality Incentive Programs

January 2025



PQIP Program Overview

Pay for Performance

Financial incentives to participating CPSP and select non-CPSP practitioners providing quality care to include timely prenatal, immunization and postpartum care to PHC members.

Entry by Invitation

Participants invited to the program are contracted Perinatal providers in Good Standing with more than 50 deliveries per year.

Measure Development

Measures are collaboratively developed and aligned with nationally reported measures

Fiscal Year Timeline

Annual fiscal-year program period measures performance beginning July 1st and ending June 30th.

PQIP Historical Highlights

2017-2021

From 2017 – 2021 the PQIP transitions from pilot to fully operational

Grows from two (2) to 49 provider sites

Incentive payout grows to over $355K

2021-2022

PQIP partners with Growing Together Program

76 provider sites

Incentive payout grows to over $360K

2022-2023

The Electronic Clinical Data System (ECDS) measure shifts from Unit of Service to Gateway measure

74 provider sites

Incentive payout grows to over $450K

2023-2024

ECDS evolves and lays the groundwork for the new DataLink implementation

76 provider sites

Incentive payout grows to over $650K

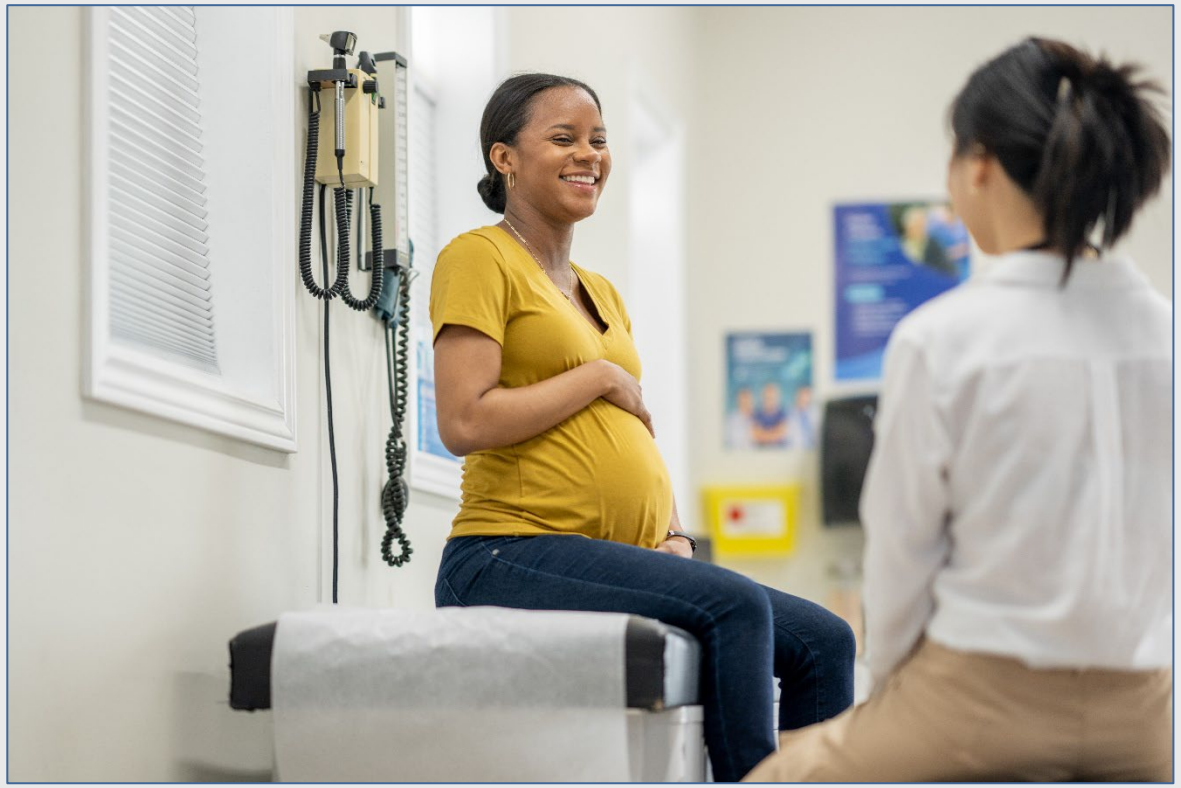
2023-24 Measure Summary

Measure	Incentive Amount Per Approved Submission	Documentation Source
Prenatal Immunization Status Tdap vaccine Influenza vaccine	 $37.50 $12.50	PHC claims system (must be provided and billed)
Timely Prenatal Care (< 14 weeks gestation)	$100.00↑	Providers submit an attestation form indicating services provided at reported visit.
Timely Prenatal Care (> 14 weeks gestation)	$25.00	Providers submit an attestation form indicating services provided at reported visit.
Timely Postpartum Care (2 visits: one visit < 21 days after delivery and one visit between 22 and 84 days after delivery)	$25 (1st visit) $50 (2nd visit)	PHC claims system (must be provided and billed)
Electronic Clinical Data System (ECDS)	$5,000 with EHR vendor support $10,000 with no EHR vendor support (Paid at the PO Level)	Depression Screening data submitted twice per measurement year on ECDS template via sFTP

Evaluation Objective

Measurement Year	
2023-2024	**Summarize** program performance.
	Assess measure results trends over time.
	Determine opportunities for program improvement or other perinatal technical assistance based on performance summary.

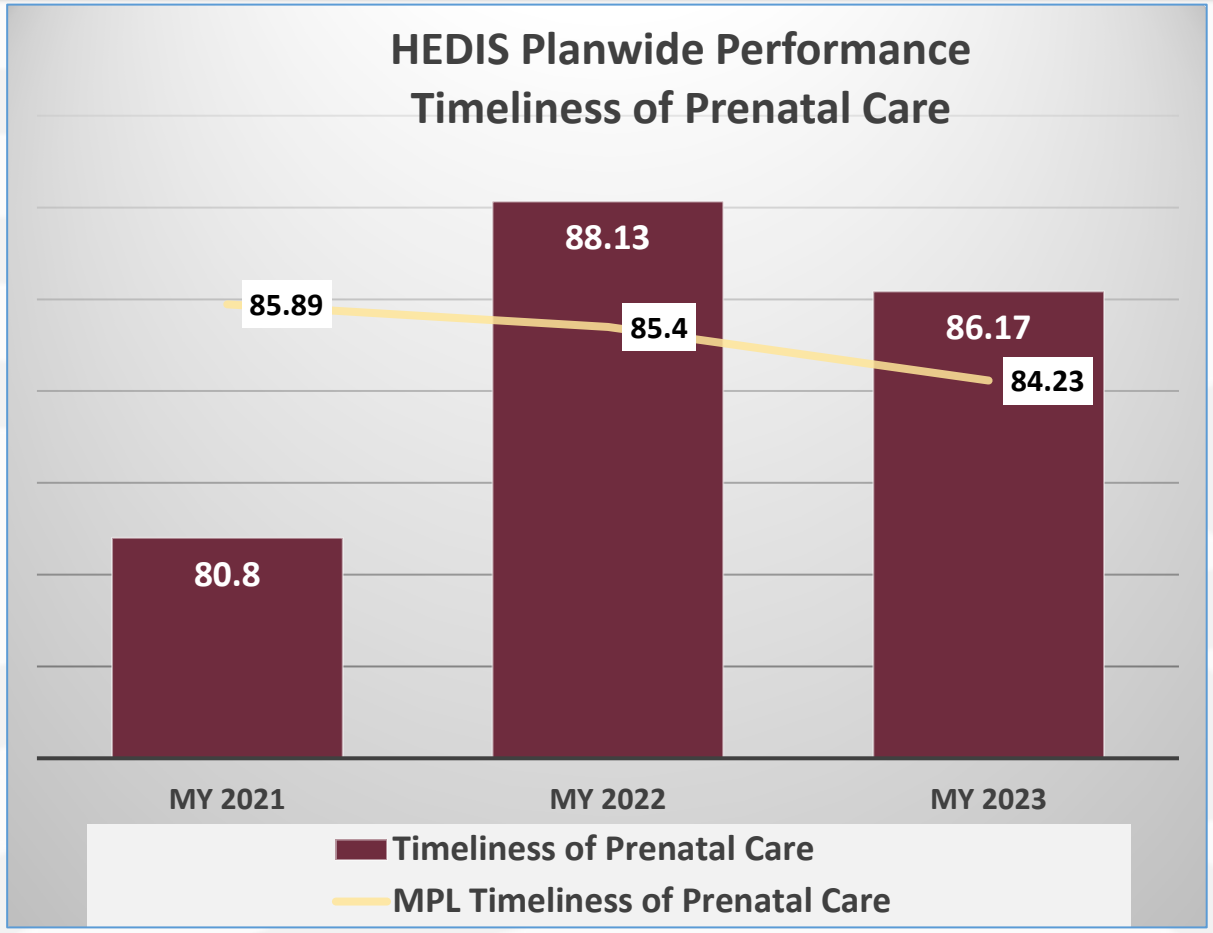
Perinatal QIP
2023-2024 Measurement Year

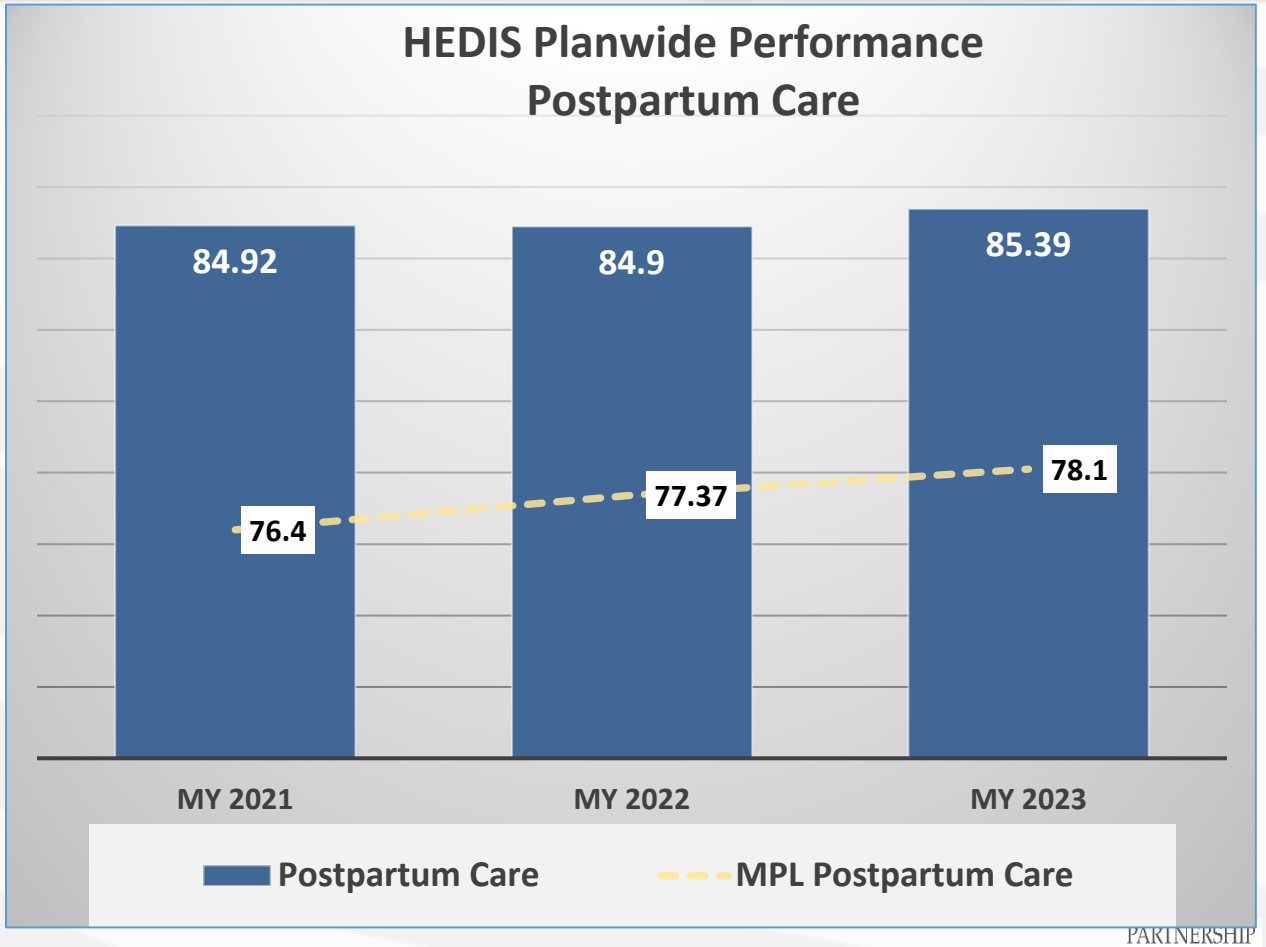


Program Evaluation

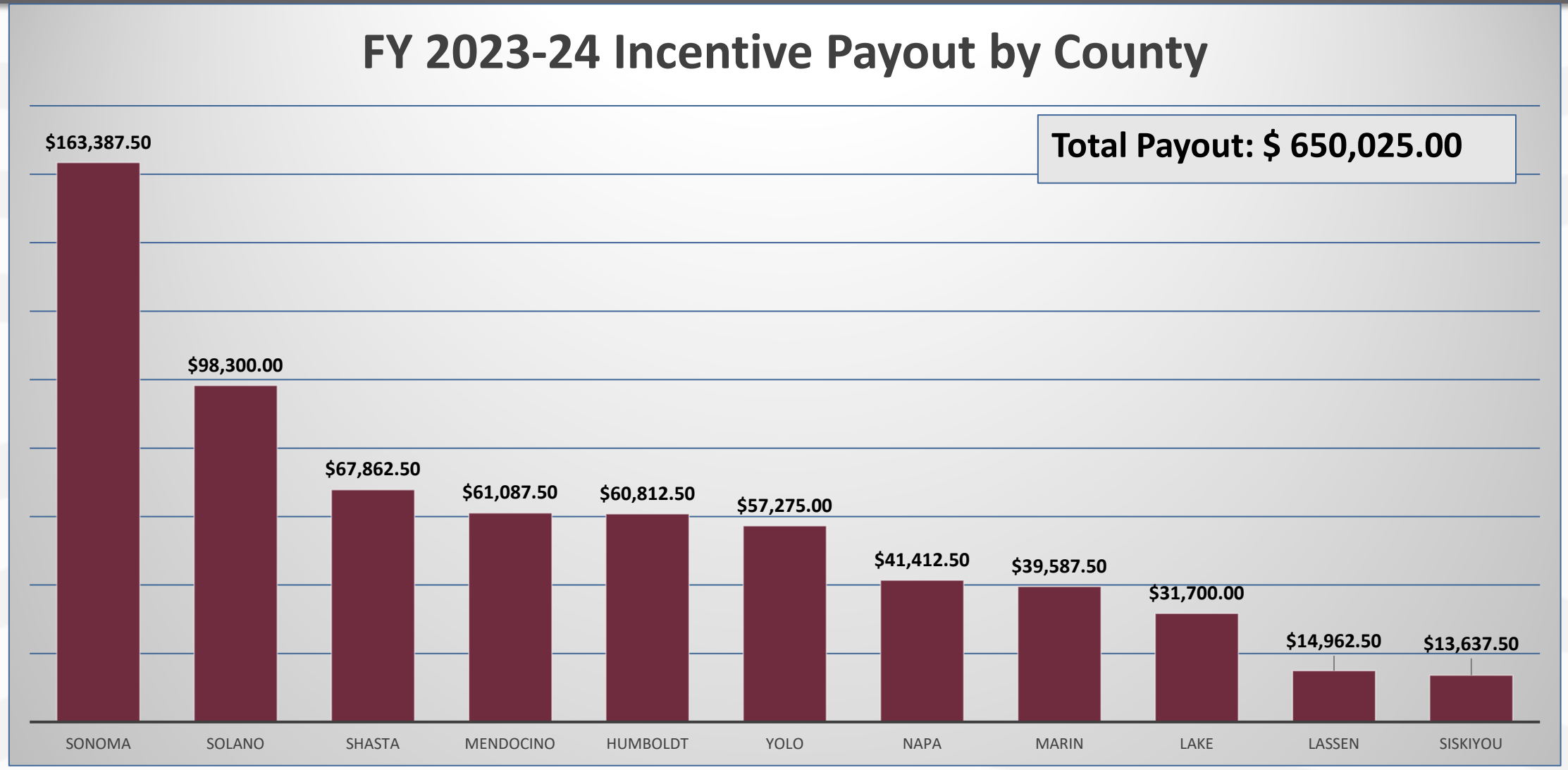
Summary

HEDIS Planwide Performance

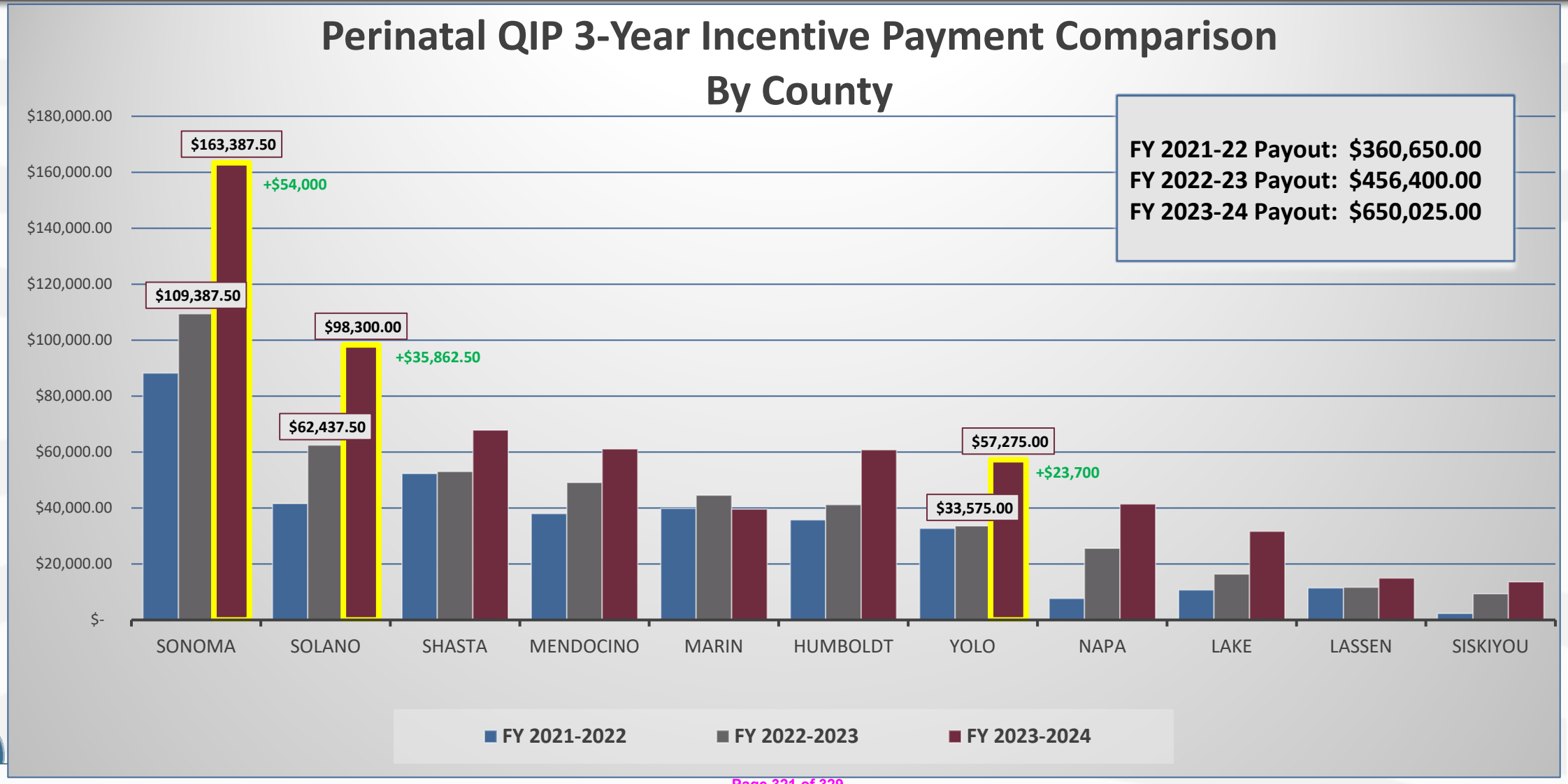




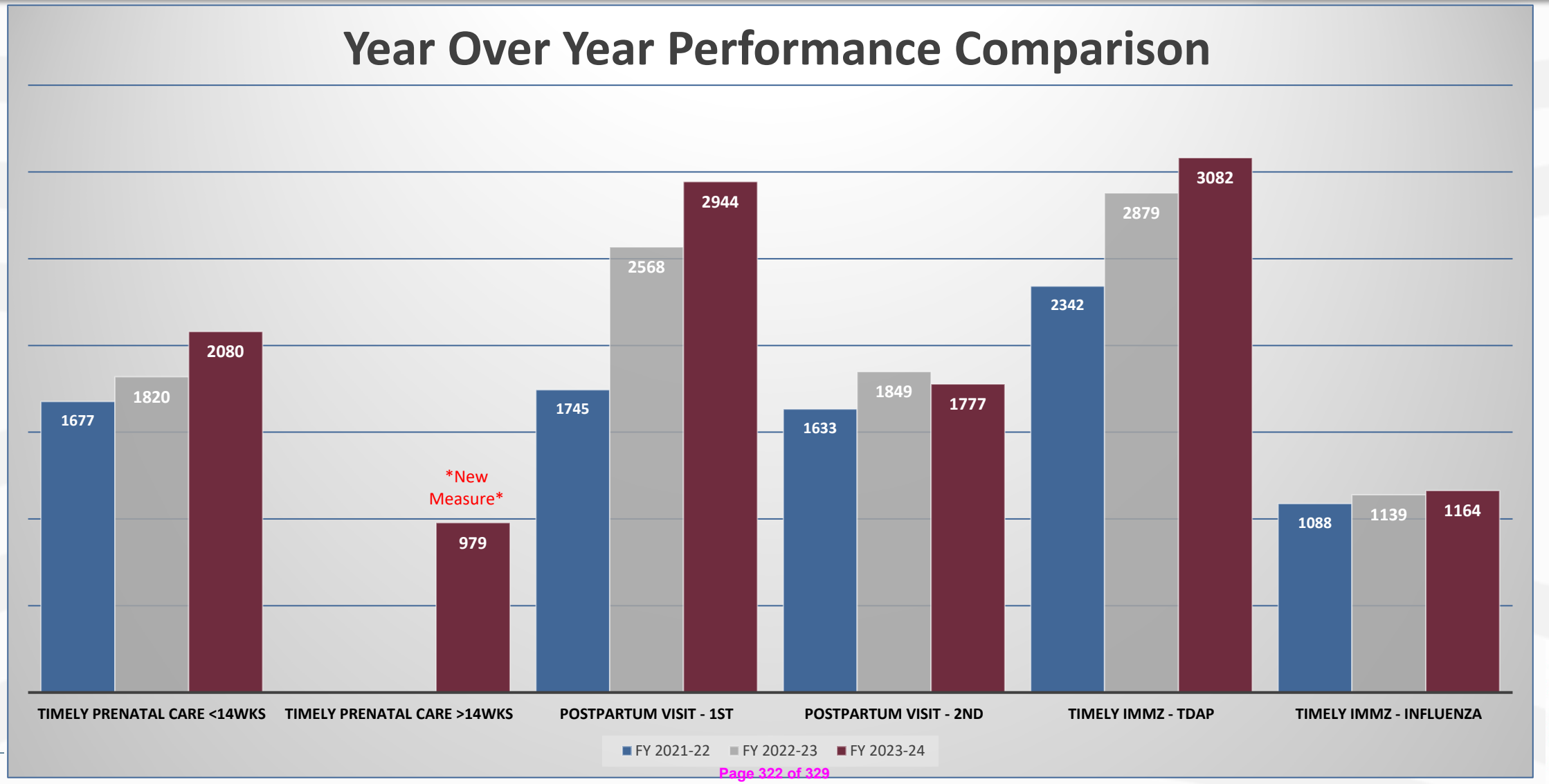
Current Incentive Payout



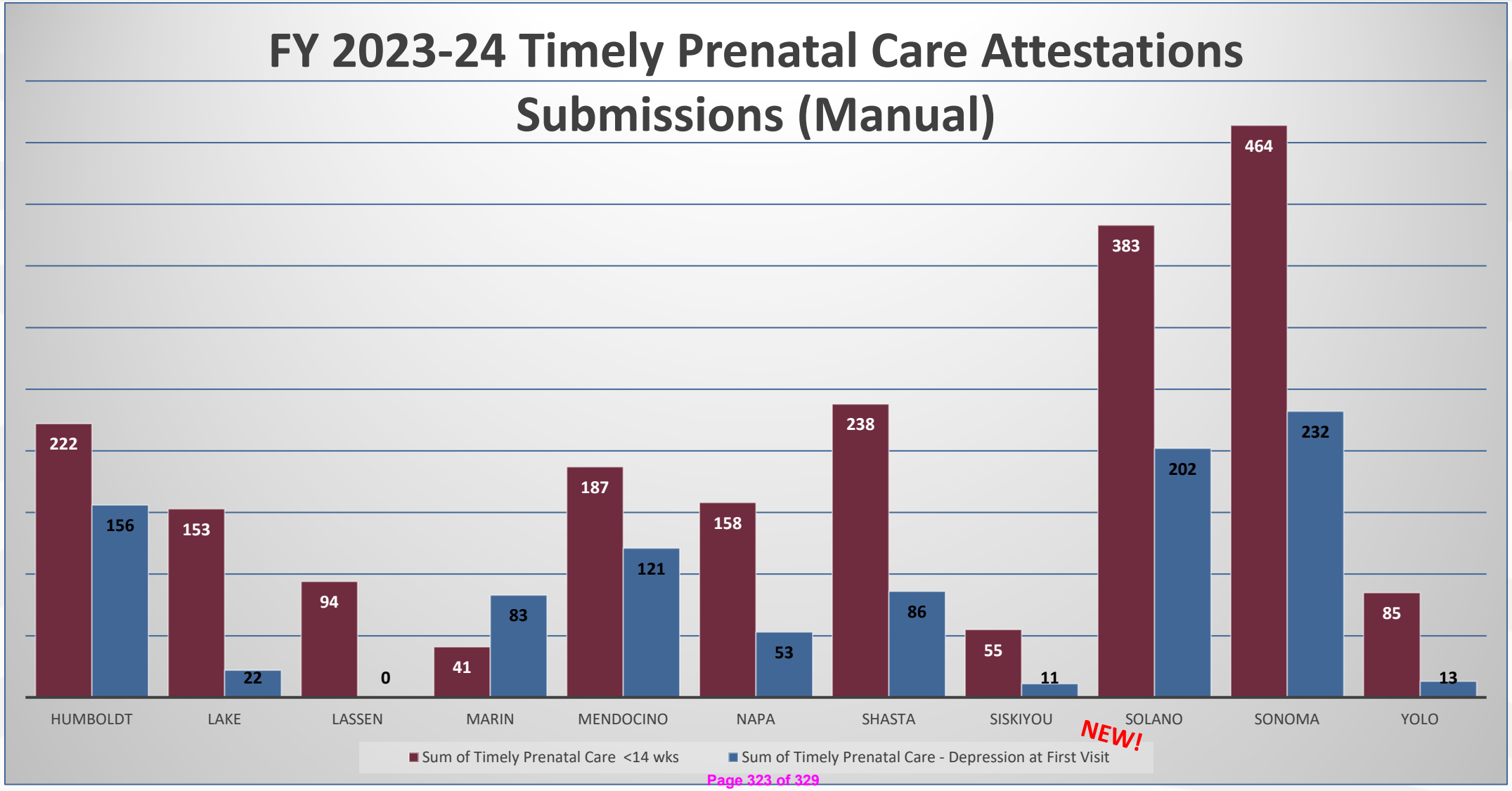
Year Over Year Incentive Payout



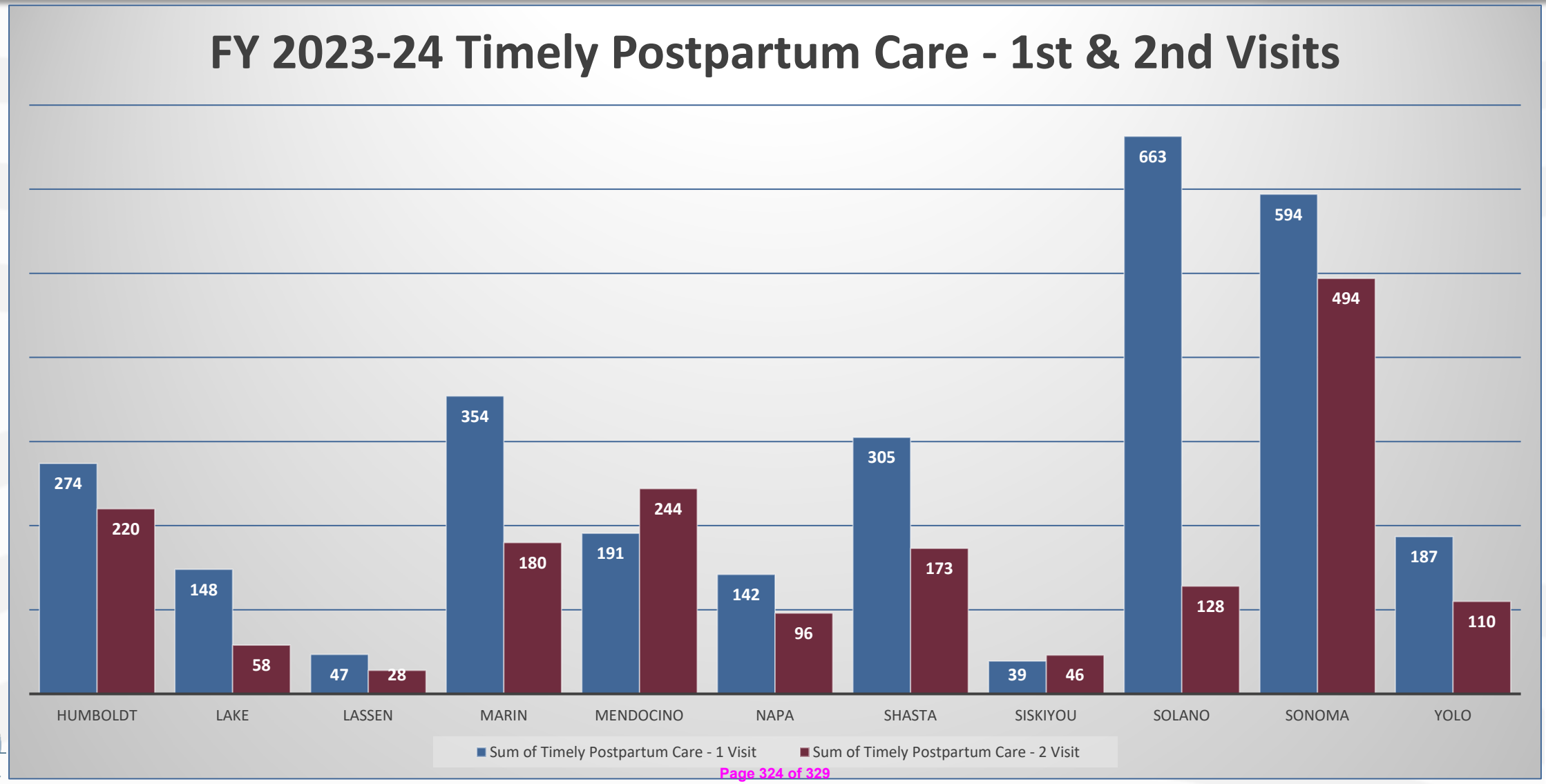
All Measures



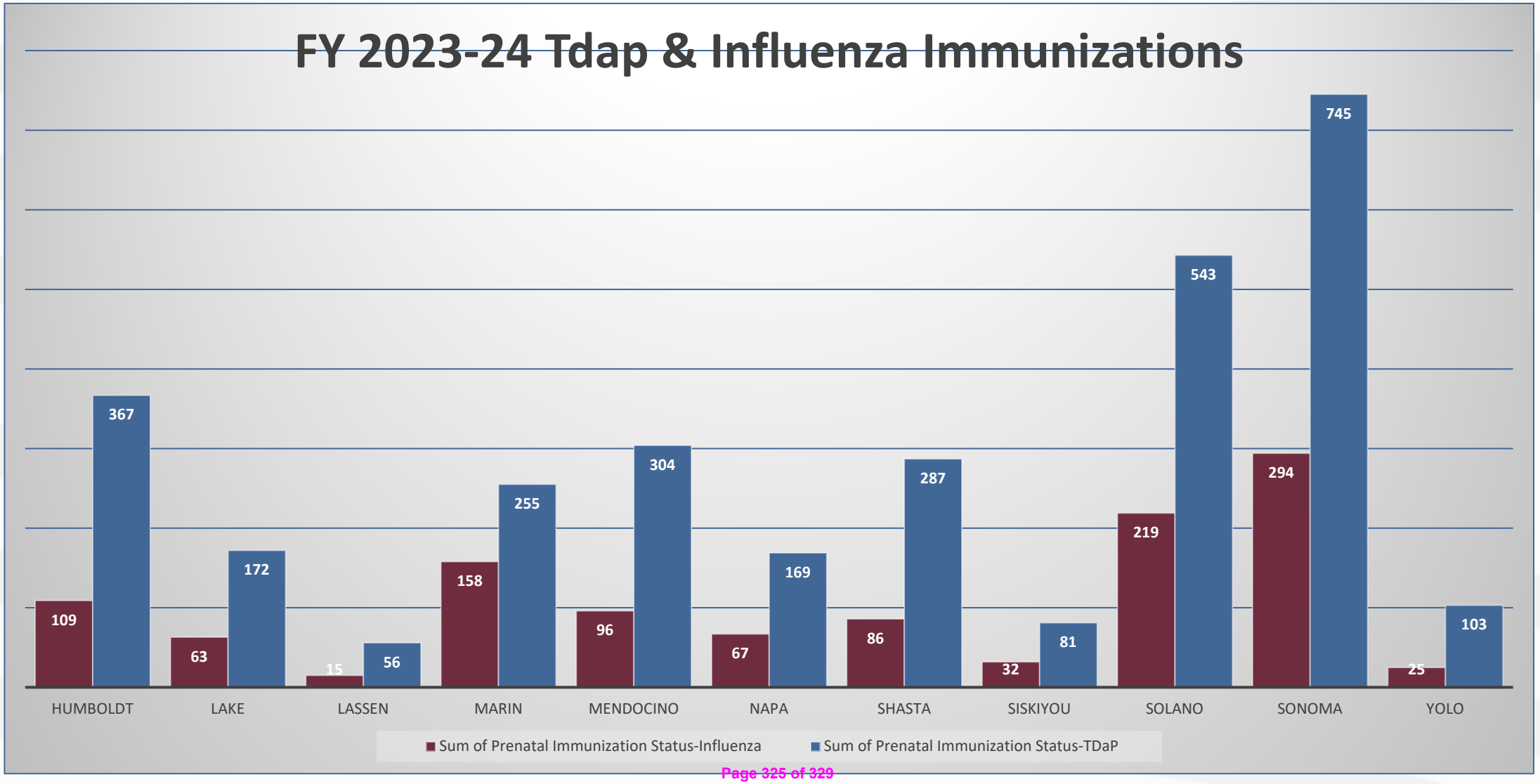
Timely Prenatal Care



Timely Postpartum Care



Timely Immunizations



Perinatal QIP
2023-2024 Measurement Year

Program Evaluation

Conclusion

Program Evaluation Conclusion

Does the Perinatal QIP continue to *improve* care?

Fiscal Year	*Approved Timely Prenatal Attestations COUNT	Timely Postpartum Care 1st & 2nd Visits COUNT	Timely Immunizations COUNT		ECDS
			Tdap	Influenza	
2023-24	↑3,059	↑4,721	↑3,082	↑1,164	10 Parent Orgs
2022-23	1,820	4,417	2,879	1,139	23 Parent Orgs

*Includes Timely Prenatal Care <14wks & >14wks

Contributing factors:

- ✓ Increased provider engagement
- ✓ Follow-up and training with providers
- ✓ PHC/provider workgroups focusing on improving overall perinatal performance
- ✓ Shift in ECDS measure requirements

Program Evaluation Summary
2024-2025 Program Recommendations and Outlook

- **Expansion Region Providers Welcomed to the Perinatal QIP**
- **ECDS shift to DataLink**

Prior Year Data Capture	• Alcohol Use Screening and Counseling (11 years and older) • Depression Screening
New Data Capture	• Standard collection of measures. DataLink has the ability to pull a much larger scope of measures than what is currently required for the PCP QIP.

DATALINK
empowering better health

- **FY 2025-26 Preparation:**
  - Continued support for expansion region providers
  - Continued support for DataLink implementation
  - Potential use of DataLink data for Timely Prenatal Care measures
  - Further development of measure set

Questions?